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A RETROSPECTIVE LOOK AT A SAMPLE OF JUVENILE SEX OFFENDERS FROM TWO LEVEL SIX RESIDENTIAL TREATMENT CENTERS IN UTAH: 1998-2007

by

Miriam Gunn

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development
(Marriage and Family Therapy)

Approved:

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UTAH STATE UNIVERSITY
Logan, Utah

2008

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ABSTRACT

A Retrospective Look at a Sample of Juvenile Sex Offenders

From Two Level-Six Residential Treatment Centers

in Utah: 1998-2007

by

Miriam Gunn, Master of Science

Utah State University, 2008

Major Professor: Dr. Thorana S. Nelson
Department: Family, Consumer, and Human Development

The study and treatment of juvenile sex offenders (JSOs) has been steadily growing since its separation from the adult sex offender category in the early 1980s. Although many studies concern themselves with one specific research variable, this study looked at the presence of twelve characteristics historically associated with JSOs: sexual abuse, early exposure to sexuality, conduct disorder problems, exposure to crime in the family of origin, personal substance abuse, family substance abuse, school performance difficulties, school behavior problems, mental health difficulties, social skills deficits, changes in family structure, and nonsexual forms of abuse. This was an effort to see if these factors are consistent in a Northern Utah sex offender treatment facility with existing literature and if any correlations of significance exist among these variables.

Data were drawn from the initial assessments of 124 clients between two centers of the Youthtrack-Utah Juvenile Sexual Offender Level-Six Residential Treatment Program through the years of 1998-2007. Results indicated that the frequencies of the factors are indeed consistent with previous studies and literature in terms of their presence among the study JSOs. There were several significant differences between facilities (mental health difficulties and social skills deficits) and multiple correlations existing among variables (frequent family structure changes, school behavior problems, family substance abuse correlating with the most variables).

Suggestions for future research include utilizing greater specificity as to how the variables are defined and utilizing the whole client file as a data source. Comparisons of the entire data file with the initial assessment might be useful, looking for initial assessment accuracy in reference to the presence of these variables in a juvenile sex offender's history. In addition, it is suggested that future studies utilize samples that include all levels of juvenile sex offender treatment, rather than exclusively level six.

(122 pages)

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In addition, my family had to hear me say much more than I wished, “Not now, I’m working on my thesis.” Thank you for your patience throughout this busy time in my life!

Miriam E. Gunn

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CHAPTER I

INTRODUCTION

There has been a significant shift in the public's awareness of the impact of juvenile sex offending within the last fifty years. The number of reported sexual offenses committed by juveniles is rising (Concepcion, 2004), though researchers are divided as to whether this is caused by increased reporting or an actual increase in occurrence. According to the Federal Bureau of Investigation, 12% of forcible rape arrests were made on children under the age of 18 in 2002 (U.S. Census Bureau, 2008). Up to one half of child molestation cases committed in the late 1990s were attributed to juveniles (Oxnam & Vess, 2006) and over half of the known adult sex offenders reported that their offensive behaviors began during adolescence (Barbaree, Hudson, & Seto, 1993; Knight & Prentsky, 1993; Saleh & Vincent, 2005; Vandiver, 2006). These costs to society are great and continually rising (Abel, Osborn, & Twigg, 1993; Witt, Bosley, & Hiscox, 2002), although these costs are impossible to estimate accurately because they include treatment for the perpetrator, incarceration/court costs, and ongoing therapy for the victims, some of which does not take place until years later. Obviously, this is a problem of some magnitude.

Definition of Terms

Much of the European literature refers to the adolescent sex offender, while in North America, the term of choice is juvenile sex offender (JSO). JSOs, most often male (Barbaree, Marshall, & Hudson, 1993) and under the age of 18 (Fortune & Lambie,

2004), perpetrate sexual behaviors that are injurious to others. These behaviors fall along a continuum ranging from exhibitionary and fondling behaviors to acts that are penetrative in nature (Barbaree, Hudson, et al., 1993).

In *Sexual Deviance* (Laws & O'Donohue, 1997), the authors stated, "One fact about human behavior that is so obvious that it needs no research program to establish . . . [is that the majority of] humans judge some sexual practices to be undesirable" (p. 1). This is certainly the case with adolescents who engage in harmful sexual activities, especially if this behavior takes the form of offensive acts against non-consenting individuals. The situation of children molesting children is a prominent issue in our modern culture, one that deserves recognition and reckoning with.

JSO Literature

For many years, the body of literature and research involving the juvenile sexual offender was remarkably sparse, though it blossomed in the mid 1980s (Bischof, Stith, & Wilson, 1992; Concepcion, 2004; Owenby, Jones, Judkinds, Everidge, & Timbers, 2001). While recent research addresses JSOs in various contexts, much of the literature describing JSO behavior regularly draws from the foundational work of Barbaree, Hudson, and colleagues (1993), as will the literature review for the current study. Saleh and Vincent (2005) expressed that much of what is known about juvenile sex offenders is drawn from retrospective research done with adults. However, because there are significant differences between adults and juveniles in terms of their physical, emotional, and mental development as well as differences within the judicial system regarding the

age of the perpetrators, there is a need for separate research and treatment models when dealing with adolescents (Barbaree, Hudson, et al.; Saleh & Vincent; Smith, Wampler, Jones, & Reifman, 2005). It seems intuitive to suggest that as more is known about the phenomenon of juvenile sexual offending, treatment can become more effective as well as possible prevention of sexual offending in general.

As with anything that deals with humanity, the phenomenon of the juvenile sexual offense is complex in terms of its development, its dynamics, and its treatment. Many books and articles describe atypical sexual behaviors (American Psychlogical Association [APA], 2000; Rathus, Nevid, & Fincher-Rathus, 2005), fewer hold ideas about how these non-normative behaviors are created, and fewer still delineate how to remedy them. Most, however, agree that this is a real and growing problem in our modern society, one that is progressive in nature and is damaging and harmful, and yet, one that is not without intervention. Barbaree, Hudson, and colleagues (1993) stated:

> The literature not only suggests a progression from less to more serious offending, but also provides an appalling picture of the damage being perpetrated by these young men. The argument that treatment should be directed toward the juvenile offender is made more potent by the suggestion that early intervention might be more efficacious, as it has the potential to treat the problem in an individual before the behavior becomes more entrenched in adulthood. (p. 11)

Treatment Levels

The Network on Juveniles Offending Sexually (NOJOS; Gourley, Bevan, & Lamb, 2007) a Utah organization, has established a continuum of eight levels of treatment services available for juvenile sex offenders, ranging from in-home treatment to lock-down residential treatment centers. Treatment at the first two levels usually involves

individual and group therapy sessions while the juvenile remains living at home; level one is outpatient psychosexual education; level two is outpatient sex-specific psychotherapy. Level three treatment involves sex-specific day treatment. Level four treatment involves day treatment at a treatment facility, but with the adolescents residing in foster or proctor home settings (out-patient sex-specific psychotherapy). Level five treatment involves sex-specific psychotherapy in either a group home setting or independent living (but the youth is no longer living at home). Level six facilities are sex-specific residential treatment centers, designed for juvenile sex offenders who have histories of sex offending that are patterned and repetitious. Level six treatment involves out-of-home placement with maximum, non-secure (line-of-sight but not lock-down) supervision and intensive intervention for sex offenders. Levels seven and eight include the previous elements, but also incorporate lock-down facilities. Level seven treatment is characterized by inpatient psychiatric sex-specific, treatment enhanced; that is, 'sex specific' means that the treatment facility treats only males or only females. 'Treatment enhanced' refers to greater focus on managing the psychiatric disturbances that by definition place these clients in either level seven or eight treatment. Clients are placed in level seven based on their psychiatric disturbances and inability to manage their mental illnesses. Level eight treatment is secure care, sex-specific treatment enhanced; these clients have demonstrated aggressive, repetitious, predatory patterns of offending, and therefore are of enormous risk in community placement (Barlow, 1998; K. Barlow, personal communication, Aug 30, 2007; Gourley et al.). It should be noted that although these are the preferred categorizations for placing JSO clients for treatment, in reality,

placement often occurs in whichever RTC has an open bed (Barlow; K. Barlow, personal communication, Aug 30, 2007).

Treatment levels are determined by professionals according to sex abuser-specific criteria, which should remain consistent throughout the entire continuum of care. Assignment to a specific level is determined by (a) level of risk posed by the client as assessed by both the client's level of self-control and the staff-to-client ratio, (b) his or her progress in treatment, and (c) competency-based decisions to move clients to a less restrictive level of care (Gourley et al., 2007).

Study Variables

As one considers this topic, numerous questions arise: who offends, why do they offend, how do they offend, and whom do they offend on, as well as where do these offenses take place?

The author of this current study was interested in a secondary analysis of data on the demographics and other data surrounding 124 male juvenile sex offenders who received treatment in two level six residential treatment centers (RTCs) in northern Utah (Youthtrack-Utah, Brigham City and Youthtrack-Utah, Logan) between the years of 1998 and 2007. The collection of data included variables generally considered by those in the field of treatment with juvenile sex offending (K. Barlow, personal communication, June 31, 2006) such as whether or not the resident was a purported victim of sexual abuse; was reportedly exposed to early sexuality; was reportedly a victim of other forms of abuse; experienced frequent family structure changes; purportedly experienced other types of

conduct disorder problems; was reportedly exposed to crime in the family of origin; reportedly experienced personal substance abuse; was reportedly exposed to family substance abuse; reportedly experienced school performance difficulties, school behavior problems, or mental health difficulties; and reportedly experienced social skills deficits.

Data Sources

The data for this study were drawn from initial assessments, which are created within the first month a juvenile is treated in Youthtrack-Utah programs. These reports are created by the primary therapist through integration of information from caseworkers, police, psychiatric evaluations, and education specialists; standardized inventories such as the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A; Hathaway & McKinley, 1940), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Youth Outcome Questionnaire (Y-OQ; Burlingame, Wells, & Lambert, 1996), the Sexual Adjustment Inventory-Juvenile (SAI-J; Lindeman, 2005); assessments on scholastic abilities such as the Woodcock-Johnson Psychological Battery (Woodcock, McGrew, & Mather, 2001); and personal interviews with clients and their parents when available. Information was gathered over one month's time for each client.

Intent of the Study

As one looks at the interplay of the various factors and information surrounding juvenile sex offenders, there seem to be some natural groupings of this material. Who are the sex offenders in terms of their behaviors and the victims they choose, and what are

the legal ramifications of their behaviors? What are the antecedents to these behaviors? What are the family structures like? As researchers add to the body of knowledge surrounding each of these three groupings, it is hoped that clinicians will gain a greater understanding of their clients and utilize the resources available to provide treatment that is increasingly more efficacious.

Juvenile sexual-offending behaviors are as wide and varied as are the children who commit these actions and therefore, all may not benefit from the same treatment approach. The intent of this study is to add current data to the information previously gathered about this population, with the hopes that greater insight may aid others in developing treatment that is individualized to the specific needs of the client.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Juvenile sex offending is a complex phenomenon involving multiple variables, many of which are interactive. The literature tends to describe these variables in a linear manner though acknowledging that these factors interact and often present in concert with each other. Attempts to find simple, singular causes for juvenile sex offending, which would hopefully lead to better treatment options, have been unsuccessful thus far. It would appear from the literature that individual, familial, and societal factors all contribute and interact in the development of contexts and factors in which children engage in inappropriate sexual behaviors (Bischof et al., 1992; Howes, Cicchetti, Toth, & Rogosch, 2000; McCormack, Hudson, & Ward, 2002).

Adding to the difficulties in understanding the phenomenon of juvenile sex offending, the literature is not consistent in its terms, behaviors are somewhat judged by the age of the youth, and most sex offense measures are not designed for use with juveniles. Words such as *rape* or *molestation* often are not consistently defined, and authors seem to assume that their terms have common definitions. Because there are no consistent definitions, terms often are defined "for the purposes of this article." For example, Smith, Monastersky, and Deisher (1987) defined molestation as non-penetrative sexual touching. However, in the adult sex-offending literature, molestation often refers to someone who victimizes children as opposed to adults (Barbaree, Hudson et al.,

1993; Saleh & Vincent, 2005). This can be confusing for those wishing to understand the phenomenon. In addition, behaviors that are considered to be problematic for adults—for example, intrusive sexual fantasies, urges, or compulsive masturbation—are often seen as normal adolescent developmental behavior that will be outgrown (Rathus et al., 2005). Furthermore, many of the measures used to assess sexualized behavior have been deemed reliable and accurate for adult populations only (Smith et al.).

Along with the lack of clarity within the literature, society itself is neither clear nor consistent about what it considers to be abnormal in terms of sexuality. The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*, (DSM-IV-TR; APA, 2000) addresses the topic of sexuality from two vantage points: (a) difficulties with the physical act itself, and (b) unusual arousal patterns or *paraphilias.* Juvenile sex offending fits into the latter category.

It is clear from reading the literature that although there is some overlap between adult and juvenile sex offender profiles in terms of characteristics and behaviors, juveniles are not younger or smaller versions of the adult offenders (Barbaree, Marshall et al., 1993; Smith et al., 2005). Over the last two decades, as more research has been done, it is apparent that it is neither ethical nor good science to extrapolate from one group to the other. In times past, an attitude of "boys will be boys" pervasively surrounded juvenile sex offending (Barbaree, Marshall, et al.; Smith et al.) and the sexualized behavior of young people was viewed as sexual experimentation (Oxnam & Vess, 2006). However, these simplistic attitudes are rarely voiced now because society currently views juvenile sex offending as a serious and costly issue that often escalates

over time (Barbaree et al.; Witt et al., 2002) demanding our attention.

Though there are many ways to organize the information describing JSOs, this author has chosen to describe (a) the normative development of sexuality, non-normative sexual behaviors and attitudes of JSOs compared to non-offending populations, the phenomena of sexual offenses, victim typology, and sex offending from a legal standpoint; (b) possible antecedents to juvenile sex offending behavior; and (c) the family structure in which these occur.

Adolescent Psychosocial Development

Normative Development of Sexuality

The term *adolescent* is a developmental term, referring to the growth stage between childhood and adulthood (Barbaree, Hudson et al., 1993; Barbaree & Marshall, 2006). In addition to the physical changes that occur with the onset of puberty, such as breast development and menarche in girls, pubic hair in both sexes, and penile and testicular growth in boys (Rathus et al., 2005), there are also behavioral/relational changes that occur during this physical transition (Bancroft, 2006; Bukowski, Sippola, & Brender, 1993). Early adolescents finds themselves with a growing curiosity and concern not only about their bodies, but also about the rules and rituals that surround their relationships (Bancroft; Bukowski et al.). If one were only talking about physical development, it would be fairly easy to delineate the typical changes that occur during this time in the life of a person; however, the concept of sexuality encompasses not only physical and emotional growth, but also a societal and cultural context, which means that

what is considered normal sexual development and activity includes a variety of behaviors and phenomena. Bukowski et al. suggested that healthy sexuality involves an integration of physical, emotional, and relational changes.

Evidence of a sexual nature in a person can appear as early as within the womb (Rathus et al., 2005) and continue on throughout the life span until death (Rathus et al.). It is not unusual to find very young children exploring their genitalia in play, though this does not appear to directly parallel later adult masturbatory behaviors (Rathus et al.). The developmental trajectory of sexuality typically includes a gradual understanding of how the sexes are different, where babies come from, what sexual intercourse is, and a sense of personal privacy and boundaries (Bukowski et al., 1993) as well as the development of a sense of sexual identity (Rathus et al.).

When the endocrine system triggers pubertal changes, sexuality becomes a marked focus for adolescents (Rathus et al., 2005). Self-concept reacts to these physical and hormonal changes (Bukowski et al., 1993). Often during this time period, masturbatory behaviors increase as do sexual fantasies and exploration of anything of a sexual nature (Rathus et al.). In general, for normal adolescents, sexual desires translate over time into dating and then physical contact, which eventually culminates in intercourse.

There is a continuum of human sexual behavior ranging from normal to atypical, which is primarily defined by cultural mores (Rathus et al., 2005). It is important to note that engaging in particular aberrant behaviors does not necessarily predict a lifetime characterized by similar behaviors (Rathus et al.) and that not all juvenile sex offenders

become adult sex offenders (Abel et al., 1993; Barbaree & Marshall, 2006; Knight & Prentsky, 1993). In addition, sexual behaviors are constrained by many things such as opportunity and societal norms and therefore, sexual behaviors of juveniles do not necessarily predict later adult preferences (Quincy, Rice, Harris, & Reid, 1993). For example, a youth may have a heterosexual orientation but offend on young boys because they are what he has available to him (K. Barlow, personal communication, June 31, 2006). As an individual ages, he or she may gain opportunities for sexual expression that match his or her mature true preferences; atypical behaviors may then no longer be seen (Quincy et al.).

Nonnormative Sexuality

Society is not at all clear nor consistent as to what it considers normal sexuality, partly because local cultures have significant input into what is defined as normative; what is acceptable in San Francisco may not be seen as such in a small rural town. Non-normative behaviors are referred to as *paraphillias*, which are defined in the DSM-IV-TR (APA, 2000) as "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons" (p. 566). Paraphillias listed in the DSM-IV-TR include *pedophilia* (attraction to children), *exhibitionism* (exposing genitals to nonconsenting individuals in public), *voyeurism* (observing sexual activity), *froteurism* (touching and rubbing against nonconsenting or unsuspecting individuals), *transvestic fetishism* (cross-dressing), *fetishism* (use of nonliving objects), *sexual sadism* (inflicting humiliation or suffering), and *sexual*

masochism (receiving humiliation or suffering). Other literature also includes *transsexualism, public masturbation, rape, obscene phone calls,* and *bestiality* (zoophilia) as examples of paraphilias (Abel et al., 1993; Rathus et al., 2005; Saleh &Vincent, 2005). Duffield, Hassiotis, and Vizard (1998) suggested that zoophilia does not exist apart from other sexual issues such as abuse of others or exhibitionism, and that it is considered to be part of an overall "syndrome" rather than a kind of offending in its own right.

Abel et al. (1993) noted that paraphilias can be inherently reinforcing because the individual committing them may experience reduction of stress, orgasm, and/or a feeling of power that they may have over another person by engaging in these behaviors. The authors stated simply that regardless of how an individual develops these aberrant arousal patterns, there is need for intervention as early as possible. Oliver (2007) concurred with Abel's work and noted that when masturbatory behaviors are entrenched in habit, they are very difficult to break and, when coupled with fantasies about younger children, can naturally lead to sex offending.

The Juvenile Sex Offender

In most jurisdictions, the term *juvenile* refers to children between the ages of 13 and 18 (Barbaree, Hudson et al., 1993; Witt et al., 2002). Juvenile sexual offenders engage in behaviors that fall within a spectrum of actions considered by society to be harmful (Barbaree et al.), primarily perpetrating on victims younger than themselves, with the exception of non-contact behaviors, such as exhibitionism and obscene phone calls, which usually involve either peers or older adults (Knight & Prentsky, 1993). Children who victimize others sexually are represented in all races, socioeconomic

statuses, and adolescent ages, with offending sometimes starting as early as pre-adolescent age nine (Barbaree, Marshall et al., 1993).

It should be noted that although the vast majority of sex offenders (juvenile or adult) are male, there are female JSOs as well (Barbaree, Hudson et al., 1993; Hunter, Becker, & Lexier, 2006). Hunter and colleagues cite a 2001 FBI study, which states that 98% of arrests for forcible rape were male, as were 92% of those arrested during the same time period for other sexual offenses excluding prostitution. According to the literature, the female JSO profile is somewhat different than that of the male profile, though there are some similarities. Hendriks and Bijleveld (2006) noted in a recent study from the Netherlands that their small sample of 10 young women offenders tended to have committed their offenses in concert with other females and in most cases, significant force had been used. Many of these girls had experienced sexual abuse themselves, as well as parental neglect. Not surprisingly, most scored low on self-esteem measures.

JSOs are divided into two categories: those who molest children, and those who assault peers or adults (Hunter, 2000; Hunter, Hazelwood, & Slesinger, 2000). Juveniles who sexually offend against children younger than themselves have a significantly different profile than those who target peers or adults. Almost 40% of their victims are relatives (Hunter; Hunter et al.). Of those who are not relatives, another 35-40% are children that the perpetrator knows; very few of the victims are strangers (Hunter et al.). Almost 50% have sexually offended on at least one male and their offenses have a greater tendency to rely on opportunity rather than force. Many of these offending youths show evidence of depression, especially if they have been abuse victims themselves (Hunter).

Those who offend against peers or adults generally exhibit higher levels of aggression, are more likely to use weapons and cause injuries (Hunter et al., 2000), tend to assault females and either strangers or casual acquaintances, and also tend to have histories of other criminal behaviors and general delinquency (Hunter, 2000; Hunter et al.). The literature does not indicate whether these young men are older than those JSOs who offend against children younger than themselves; however, this would be an interesting question for future research (Hunter; Hunter et al.).

Juvenile sex offenders are not alike in the manner in which they victimize others; some are coercive and some are noncoercive in their offending patterns (Leclerc, Proulx, & McKibben, 2005). In a study of 23 male juvenile sex offenders who were given a self-report measure, the Modus Operandi Questionnaire (MOQ; Kaufman, Hilliker, & Lathrop, 1994), results indicated that those JSOs who used non-coercive methods for obtaining sexual contact with the person they victimized often did not need to use threats to obtain compliance or the victim's silence because they had already "groomed" them, establishing trust, friendship, and desensitizing them by using nonsexual touching before they touched them sexually (Leclerc et al.).

Some literature categorized JSOs in terms of their offense pattern repetition. There are one-time offenders as well as repeat offenders, both before and after receiving treatment (Vandiver, 2006). As researchers look at recidivism for post-treatment offense rates, both sexual and non-sexual behaviors are monitored; some juveniles will continue to commit one or both kinds of offenses after treatment and some will commit neither (Vandiver).

Literature on juvenile sex offenders and empathy research suggests that JSOs experience deficits in empathetic concern for others, especially in situations that are characterized by intense emotions (Lindsey, Carlozzi, & Eells, 2001). These children also tend to show a lack of personal distress in the face of the suffering of others (Lindsey et al.). Because of this empathetic deficit, much of JSOs' treatment has incorporated empathy development as a significant part of the treatment plan (K. Barlow, personal communication, May 31, 2006).

Sexual Offenses

Researchers categorize sexual offenses based on the type of offense (Ertl & McNamara, 1997). *Hands-off* offenses, a term used in the literature, include non-physical acts such as voyeurism, obscene phone calls, and exhibitionism, while *hands-on* offenses describe sexual assault and rape (Duane, Carr, Cherry, McGrath, & O'Shea, 2003; Ertl & McNamara; Hendriks & Bijleveld, 2004). In countries other than the United States, further delineations are made as to the solo or group nature of offenses (Bijleveld & Hendriks, 2003). Bijleveld and Hendriks stated that two-thirds of the juvenile sex offending that occurs in the Netherlands occurs in the form of group rape.

Much of the literature defines the phenomena of rape and molestation differently; some does not define either at all, assuming that the reader understands the terms. Within JSO literature, the authors define *rape* as "sexual assault against women [sic] above the age of consent" and *child molester* is defined as "men [sic] who have been convicted of a sexual assault against a child" (Barbaree, Hudson et al., 1993, p. 4). White and Koss (1993) stated that the concept of *rape* is socially constructed and that any instance of

forced sex might be labeled as such. The authors described a full spectrum of means that the perpetrator (juvenile or adult) utilizes to obtain sexual contact ranging from psychological pressure, threats, physical intimidation, mild physical force such as pushing or slapping, use of alcohol or drugs to gain compliance, severe physical force such as beating or choking, and displaying or using a weapon. In other words, an act does not have to be violent to be rape; it could be merely coercive.

Victims

Typically, most victims are known to the perpetrator (Barbaree, Hudson et al., 1993) and are younger children, with the exception of non-contact offenses, such as obscene phone calls or indecent exposure, in which case, the victims typically are peers or adults (Barbaree et al.). When the offense is assaultive, the majority of the victims tend to be female; however, when victims are younger, they are almost equally male and female (Barbaree et al.).

Legal System

Within the legal system of our country, there is a distinction between adult and juvenile criminal processes. Although both systems seek to protect society, the juvenile criminal justice system also seeks to rehabilitate delinquent children (Bala & Schwartz, 1993; Barbaree & Cortoni, 1993; Concepcion, 2004; Koss, Bachar, & Hopkins, 2006), which is often not the case with adult sex offenders (Barbaree, Hudson et al., 1993). There appears to be widespread acceptance of the idea that incarceration alone does not change sexual-offending behaviors (Barbaree & Cortoni). There is a generalized

agreement that adolescent offenders do not possess the internal discipline to pursue treatment on their own, and therefore, court-mandated treatment is necessary (Barbaree & Cortoni).

In the mid-to-late 1990s, three federal statutes were created following several sexual assaults that were committed by repeat offenders: the Jacob Wetterling Act, "Megan's Law," and the Pam Lychner Sexual Offender Tracking and Identification Act (Hunter, 2000; Letourneau, 2006). Each of these dealt with the registering of adult sex offenders. Convicted sex offenders must register for a minimum of 10 years, with those considered "high risk" having to register for life (Letourneau). Each state has its own laws regarding the specifics of how sexual offenders are to register and whether or not juvenile sex offenders are required to do so. Currently, in the state of Utah, convicted JSOs are not on a sexual offender registry. This may change in 2009 with the federal Adam Walsh bill going into effect (K. Barlow, personal communication, October 15, 2007). The goals of these registries are deterrence of would-be sex offenders and immobilization of those who are not deterred (Letourneau).

Treatment

Similar to the complexities of description, treatment of juvenile sex offenders is also not a simple issue, due in part to the attitudes of the offenders and the difficulties surrounding empirical research. Treatment options more than doubled from the mid-1980s to the early 1990s (Hunter, 2000), ranging from individual therapy to complete lock-down residential treatment. Many residential treatment centers utilize cognitive behavioral therapy in addition to other forms of behavior modification (K. Barlow,

personal communication, June 31, 2006). The sexual offenses of two juveniles may appear similar--for example, the molestation of a child; however, the motivation to offend may be significantly different and therefore may merit different treatment (Långström & Lindblad, 2000; Saleh & Vincent, 2005). The average JSO may not be motivated sexually, but rather may offend out of feelings of anger or hurt or revenge or other strong negative emotions. In the face of these negative emotions, adolescents have difficulties self regulating or managing their emotions in an appropriate manner (K. Barlow, personal communication, June 31, 2006). Many current treatment programs rely on training in self regulation and then educating about relapse prevention. Many also include the concept of *restorative justice*, meaning that perpetrators have obligations to "make things right" through a process of "repair, reconciliation, and reassurance [that the crime won't happen again]" (Koss et al., 2006, p. 341).

Hunter (2000) stated that it is difficult to conduct controlled treatment outcome studies for both funding and ethical reasons; however, he noted that several studies do suggest that recidivism rates based on re-arrests indicate that therapy programs that address the client's whole system (the individual, the family, and the community) appear to be significantly more effective than therapy that only addresses the individual.

In general, the literature agrees that treatment for juvenile sex offenders should be highly structured, sex-offender specific, and conducted in a sex-offender-specific treatment setting (Barbaree & Cortoni, 1993). Many of the current treatment programs utilize empathy-enhancement interventions as part of their overall sex-offender treatment regime (Lindsey et al., 2001). Denial and minimization among sex offenders seems to be

the rule, not the exception, and adolescents that admit to their offenses generally minimize the frequency and severity of their behaviors (Barbaree & Cortoni); treatment, therefore, often focuses on getting youth to take responsibility for their actions and not minimize them (K. Barlow, personal communication, May 30, 2006).

"Studies show that androgen levels affect sexual interest, erections, sexual fantasies, and sexual behavior" (Bradford & Fedoroff, 2006, p. 361) and therefore it is reasonable to think that pharmacological interventions might be of some use with JSOs. However, due to the developmental growth that adolescents are in the midst of by definition, great care must be used with any intervention utilizing drugs (Bradford, 1993; Bradford & Fedoroff) because some of their side affects have been shown to affect height (Bradford). "While not totally contraindicated, antiandrogens or hormonal agents are not used prior to age 16, which is the outside limit for the expected development of puberty" (Bradford, p. 281). Bradford and Fedoroff stated that selective seratonin reuptake inhibitors (SSRIs) are becoming more acceptable in the treatment of sexually deviant behaviors; the most common SSRIs used are sertraline and fluoxetine (Bradford & Fedoroff). Drugs that block dopamine have also been found to be effective, with observations of these kinds of drug treatments supporting the idea that sexually deviant behavior and compulsive behaviors are related. In addition to SSRIs and dopamine blockers being main forms of pharmacological treatment, antiandrogens that prevent testosterone uptake and therefore reduce plasma testosterone levels such as cyproterone acetate (used in Canada) and medroxyprogesterone acetate (used in the United States), and luteninizing hormone-releasing hormone agonists (which cause chemical castration),

such as leuprolide acetate and goserelin acetate are other avenues of treatment via drugs that are currently utilized in the treatment of JSOs (Bradford & Fedoroff). However, it must be noted that these drugs are prescribed “off label,” meaning that they are not approved by the FDA for the purpose of treatment of JSOs and that currently, funding for pharmacological treatment of JSOs is very poor (Bradford & Fedoroff).

Antecedents and Correlates

The research that has been done suggests that juvenile sexual offenders are a heterogeneous group (Barbaree, Marshall et al., 1993; Duane et al., 2003; Hendriks & Bijleveld, 2004), yet both research and treatment literature lament the struggle for empiricism in light of the fact that there are so many variables and difficulties in defining both the specific nature of the problem and which treatments are effective (Laws & O’Donohue, 1997). Although the literature is consistent in the variables it lists as factors in juvenile sexual offending, there is a tendency to view and describe these linearly, though it is mentioned that they often present together. The challenge to researchers is to try to understand relationships among factors of motivation, antecedents, cause, and influence.

According to the literature, family of origin has a vital impact (Bischof et al., 1992; McCormack et al., 2002), as does trauma and perhaps a personality propensity for reacting to distress in sexualized ways (Rasmussen, 2005). Additionally, differing forms of abuse are often experienced simultaneously within a family, such as physical, sexual, and emotional abuse and/or neglect (Howes et al., 2000).

When surveyed, juvenile sex offenders present a diverse set of antecedents such as psychotic disorders, alcohol or other drug use that may effect inhibitions, personality or cognitive deficits that might make a person more vulnerable to offending actions, reactions to their own abuse, genetic components, genetic abnormalities that may predispose toward sexual paraphillias, abnormal hormonal levels, or even brain injuries that impact behavior (Vandiver, 2006). Because these often occur concurrently, it is clear that juvenile sex offending does not take a linear cause-and-effect pathway. It is difficult to ascertain which of the factors are precipitating and which are effect phenomena. In addition to these individual factors, many JSOs' parents report they had similar issues as their offspring: they also were abused as children, have genetic contributors, and experienced fractured and low family cohesiveness in their own families of origin (Howes et al., 2000). It should be noted, however, that the literature on JSOs' family contexts is sparse and in general does not provide much information. Family factors will be discussed at greater length in the section on family characteristics.

Psychological Profiles

In the late 1980s, McCraw and Pegg-McNab (1989) indicated that although there have been many attempts to describe the behavioral characteristics of JSOs, there has been less effort to understand their psychological health; however, since then, attempts have been made to do so. In a study of 262 juvenile sex offenders who were administered the MMPI-A (Hathaway & McKinley, 1940), researchers found that, contrary to previous research, delinquents did not fall into a homogenous personality profile; rather, they demonstrated four main personality categories: those with conduct disorders, those with

personality disorders, those who were immature, and those with social delinquencies (Smith et al., 1987). Hunter (2000) stated that it is very common for JSOs to also present with other behavioral problems. He noted that up to 80% of JSOs have some diagnosable psychiatric disorder. This finding was consistent with older data, which indicated that 70-87% of JSOs presented with psychiatric problems (Barbaree, Hudson et al., 1993).

Social Structures

Lack of social competency appears to be a significant factor in sex offending in general (Barbaree, Hudson et al., 1993; Bijleveld & Hendriks, 2003; Hendriks & Bijleveld, 2004; Knight & Prentsky, 1993; Långström & Lindblad, 2000). Studies of adult offenders continue to corroborate this idea, with child molesters demonstrating even greater social deficits than rapists (Hunter, 2004). Knight and Prentsky noted that some of the most common characteristics used to describe juvenile sex offenders are those of social deficiency. It is theorized that these deficits contribute to emotional loneliness, which may increase the probability that individuals will become aggressive toward others in an attempt to get social needs met. This social isolation often contributes to an already low self-esteem (Marshall & Eccles, 1993).

Hendriks and Bijlveld (2004) found in their study of 116 male juvenile sex offenders that those who perpetrated on prepubescent children demonstrated greater depression and anxiety and showed greater deficits in psychosocial functioning than those who offended on post-pubescent children. Hunter (2004) stated that those who "manifest psychosocial deficits are more likely to engage in threatening and aggressive behavior with other males in sexual competitions, and utilize sexual coercion with

females" (p. 234). Hunter noted that a differentiating factor when looking at juvenile sexual offenders versus non-offenders is the presence of deficits in self-sufficiency, especially when paired with pessimistic attitudes.

Nonsexual Criminal Behaviors

Juvenile sex offenders commonly present a history of delinquency (Barbaree, Hudson et al., 1993; France & Hudson, 1993; Knight & Prentsky, 1993; Marshall & Eccles, 1993; McCraw & Pegg-McNab, 1989; Seto & Lalumiére, 2006; Smallbone, 2006; Smith et al., 1987). It is not unusual for adolescent sex offenders to establish criminal records by the time they are apprehended for sexual offenses. These offenders are typically diagnosed with *conduct disorder,* which is defined by the DSM-IV-TR as:

> a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals, . . . nonaggressive conduct that causes property loss or damage, . . . deceitfulness or theft, . . . and serious violations of rules. (APA, 2000, p. 94)

Delinquency refers to behavior that leads to contact with the courts (France & Hudson, 1993). In research that involves interviews with JSOs, the literature indicates it is rare for an individual to report that he was caught in his first sexual offense (Hunter, 2000; Hunter et al., 2000).

Sexual offenders have often committed other criminal acts. Långström & Lindblad (2000) reported in their study of 56 Swedish youthful sexual offenders that over 50% of their sample had previously been convicted of a crime; 23% had been convicted more than once. France and Hudson (1993) stated that 41% percent of adolescent rapists

in their study had previous criminal records and 63% had participated in delinquent activity. These statistics are consistent with the findings presented in most literature (France & Hudson). However, despite these findings, not all JSOs engage in antisocial behavior.

Hands-off perpetrators as well as nonaggressive JSOs do not present the same profiles in terms of their crime histories as do hands-on and/or aggressive JSOs (France & Hudson, 1993). Hands-on juvenile sex offenders seem to have more similarities to antisocial adolescents than the other groups of JSOs in their use of violence, substance abuse, personality profiles, and lack of acquaintance with their victims (France & Hudson).

Problems in School

Typically, juvenile sex offenders demonstrate poorer than average academic performance (Barbaree, Hudson et al., 1993; Concepcion, 2004; Duane et al., 2003). Hunter (2000) noted that 30-60% of JSOs demonstrated learning disabilities. Concepcion noted that many preadolescent sexual offenders have average to lower IQs, with almost half of them in the low-average to borderline range. This ratio of average to lower IQs is twice as high as that found in a normally distributed population. These findings were consistent with literature (Blanchard, Cantor, & Robichaud, 2006; Knight & Prentsky, 1993). It has been questioned whether cognitive and organic deficiencies may be more associated with violence in general rather than with sexual violence specifically (Knight & Prentsky). Knight and Prentsky also found that youth with IQs lower than 80 tended to display more aggressive behavior than youth with higher IQs.

In a study of 30 male adolescent sex offenders and 20 age-matched non-offending males, Kelly, Richardson, Hunter, and Knapp (2002) found that there were significant differences between the groups in terms of their attention and executive abilities. The authors reported surprising findings that JSOs in their sample reflected attention deficits; however, unlike the deficits demonstrated by ADHD and/or conduct-disordered children, JSOs' deficits were similar in nature to adolescents who had experienced head injury such as reduced speed of performance-timed tasks as well as problems sustaining and/or switching attention. These results caused the authors to entertain the idea of neurological trauma as a possible factor in the development of sexual offending behavior. Despite the fact that this was a small sample, the authors stated, "while there is unlikely to be a specific neuropsychology of sexual offending, the data does indicate that there may be significant neuropsychological deficits in adolescent sex offenders" (p. 142).

Developmental Disabilities

Stermac and Sheridan (1993) found in their comparison study of 24 adolescent sex offenders with special needs and 155 sex offenders with no special needs that developmentally delayed individuals were more likely to engage in inappropriate sexualized behaviors such as public masturbation, exhibitionism, and voyeurism. According to Stermac and Sheridan, this group of adolescents generally offends equally among males and females, adults and children, and usually their victims are people who are known to them. These children also experience a lack of social and assertiveness skills, feelings of low self-esteem, social isolation, and high family dysfunction. Stermac and Sheridan stated that this population is four times more likely to be victims of sexual

abuse as well as to exhibit significantly greater behavioral problems.

Early Exposure to Sexuality

Early exposure to sexuality can come in a variety of forms, such as observing adults engaging in sex, overhearing sexual activity, or exposure to various forms of pornography, which has its own range of explicitness (K. Barlow, personal communication, October 15, 2007). Although the full ramifications of these early exposures to sexuality are not known, White and Koss (1993) stated, "Early sexual experiences, including sexual victimization, have been found to be predictive of sexual aggression" (p. 188). Malamuth, Addison, and Koss (2000), in a meta-analysis of studies on pornography, summarized their findings by stating, "there is much consistency for an association between exposure to violent pornography and aggressive responses" (n.p.). Marshall and Eccles stated that "much of the imagery in pornography, advertising, and the general media . . . depict women to be compliant with men's sexual desires, as unlikely to be rejecting, and as responsive to coercion" (p. 175). The authors asserted that it is possible that adolescents who are lacking in social skills are more responsive to pornographic images, in part because their responses to these images do not require social skills, which many of these boys do not posses. When pornography is used in masturbatory practices, thought/behavior patterns are reinforced, and therefore, difficult to alter (Abel et al., 1993; Marshal & Eccles, 1993). Barabee and Langton (2006) stated that families of children with sexual behavior problems (not all of whom became JSOs, yet all JSOs were found to have sexual behavior problems as younger children) had been found to either promote or allow exposure to sexual material and/or behaviors at an early

age. In a comparison study of JSOs, non-violent offenders, and violent non-sexual offenders, it was found that 42% of the sexual offenders reported exposure to hard-core sex magazines compared to 29% of the non-violent offenders and violent non-sexual offenders.

In a nationally representative telephone study, the Youth Internet Safety Survey (Ybarra & Mitchell, 2005), 1,501 children ages 10-17 self-reported pornography-seeking behaviors. Results indicated a connection between use of pornography, whether online or through traditional sources such as magazines, and delinquency and substance abuse during the previous year (Ybarra & Mitchell). In addition, the children reported lower levels of emotional bonding with their caregivers. Fifty percent of the online seekers of pornography in this study indicated physical or sexual victimization (Ybarra & Mitchell). It is estimated that 90% of children in America have access to the Internet (Ybarra & Mitchell) and although the literature does not indicate that pornography creates sex offenders, it seems reasonable to assume that there is an interactive effect of pornography with other variables, such as prior sexual abuse or other forms of early exposure to sexuality coupled with a lack of parental guidance (Stewart & Healy, Jr., 1989).

Prior Physical and Sexual Abuse and Neglect

Prior sexual abuse is often a common factor in the background of JSOs (Abel et al., 1993; Barbaree & Marshall, 2006; Barbaree, Hudson et al., 1993; Burton, 2003) as is physical abuse (Knight & Prentsky, 1993). It is hypothesized that those who offend on others are working out their own abuse (Barbaree & Langton, 2006); often, the abuse these children perpetrate on others is a replica of the abuse they themselves previously

experienced (Abel et al.; Burton; Barbaree & Langton). There seems to be some evidence of this in relation to sexualized acts that are aggressive in nature (Burton; Knight & Prentsky). According to Burton, up to 80% of adolescents who sexually offend on other children have been offended on themselves. Burton stated that 82.4% of RTCs and 89% of community-based treatment programs in North America recognize the perpetrator's own abuse as a significant factor in their offensive behaviors, and therefore utilize therapy and programs designed to address this abuse in juvenile sex offender treatment. Estimates quoted by McCormack and colleagues (2002) suggest up to 47% of JSOs have experienced some form of sexual abuse. "Thus, a history of sexual victimization and sexual deviation within the home has been found to be highly predictive of sexual aggression" (McCormack et al., p. 86).

Although we must be careful to not assume cause and effect, it is notable to look at some of the correlations of sexual offending with factors such as abuse. It has been demonstrated that abused children show less empathy than nonabused children (Farr, Brown, & Beckett, 2004; Knight & Prentsky, 1993; Lindsey et al., 2001). In the discussion of results of their study of 81 JSOs and empathic responses, Lindsey and colleagues noted that the differences they found in empathic concerns may be related to the severity and the early age at which these JSOs were victimized themselves. According to two studies, abused children also have more difficulty recognizing appropriate emotions in others and in taking the perspective of another, and they are less concerned with the distress of their peers (Farr et al.; Knight & Prentsky). Thus, it is easier for them to offend on others, not taking into consideration the feelings or

experiences of the person they victimize (Farr et al.; K. Barlow, personal communication, June 30, 2006). Knight and Prentsky conducted a study of 564 male sex offenders where they separated their sample into those who had been charged with sexual offenses as juveniles and those who had not, and then further divided them into categories of child molester and rapist as defined by the age of the people they victimized (under or over age 16). Knight and Prentsky found that there were consistent group differences for the rapists and the child molesters. The authors found that JSO child molesters, defined as having sex with victims under the age of 16 (n = 207), appeared to have experienced more physical abuse than non-JSO child molesters and JSO rapists, defined as having sex with women over the age of 16 (n = 254), and seemed to have experienced more neglect than non-JSO counterparts. The remainder of the sample could not be categorized as either child molesters or rapists because they fell into both age categories. The authors suggested that personal abuse and/or neglect does have an effect on offending behavior.

Substance Abuse

It is curious that little of the literature devotes space to the discussion of substance abuse and juvenile sex offenders other than to mention that it can be a factor; there have been few empirical studies conducted to assess whether there is or is not a relationship between the two. Hunter (2000) and Knight and Prentsky (1993) stated that JSOs consistently demonstrated difficulties with impulsivity and judgment apart from the context of substance abuse. Lightfoot and Barbaree (1993) suggested that alcohol further impairs judgment centers in the brain and heightens impulsivity, decreasing the threshold for aggression and having a disinhibiting effect on sexual behavior.

It is clear from the literature that the antecedents and correlates to juvenile sex offending are many and are interrelated. These factors contribute to the difficulty in studying this population. The intent of this study was to look at the prevalence of these factors in the current sample in the hopes of providing a clearer picture of JSOs.

Family Characteristics

Chaotic and Maltreating Families

In general, juvenile sex offenders experience a high incidence of family instability (Barbaree & Langton, 2006; Marshall & Eccles, 1993). Sexual offenders, juveniles being no exception, reported negative early events associated with insecure attachment styles and reported negative relationships with both parents (Ainsworth, Blehar, Waters, & Wall, 1978; McCormack et al., 2002). They reported less communication with their parents and fewer consistent relationships with their caregivers. Much of the current literature suggests that the majority of juvenile sex offenders come from maltreating homes (Barbaree & Langton; Barbaree, Hudson et al., 1993; Bischof et al., 1992; Price, 2005).

It is difficult to ascertain accurate statistics surrounding these factors because most maltreating behaviors are illegal and are therefore often not reported due to fear of possible consequences such as removal of the children. Furthermore, maltreating behaviors are often not clearly observed nor reported in a reliable fashion (Howes et al., 2000). Howes et al. stated:

> Family interaction research in maltreating families is challenging for at least two reasons. First, defining the family system in homes where

> maltreatment occurs is difficult. Such families are frequently changing. . . . Because of the transient composition of these families, the family as a basic unit is not stable. . . . Many maltreating families exhibit varying degrees of emotional abuse, neglect, physical abuse, or sexual abuse concurrently or at differing points in time. (pp. 95-96)

In a Swedish study of 57 juvenile sex offenders, only 12% came from "a harmonious psychologic [sic] family climate" (Långström & Lindblad, 2000, p. 115). Hunter (2004) stated that exposure to violence, especially male-modeled antisocial behavior, has a significant effect on sex offending.

Rigid or Poor Boundaries

Bischof et al. (1992) found that juvenile sexual offenders in their study tended to come from families that either had rigid boundaries with unbending rules or families with almost non-existent boundaries where there was chaos and role confusion. Further, Howes et al. (2000) stated:

> Sexually abusive families had significantly more difficulties regulating anger, evidenced more chaos and less role clarity, and relied less on adaptive-flexible relationship strategies than non-maltreating families. . . . It is common for one or more family members to move in or out of the home with frequency. Maltreating families can be expected to be more chaotic and less effective in working together toward the achievement of common goals that foster competence and a healthy sense of self. (pp. 95-96)

Bischof et al. (1992) noted correlations between the level of offenses and the amount of rigidity and disengagement in the family. Part of the observed chaos took the form of communication deficits, which seemed to hold true in other cultures as well; Duane et al. (2003) listed poor communication between parents and sexually abusive youngsters as a consistent finding in Ireland.

Lack of Parental Support

Ream and Savin-Williams (2005) found that sexual activity among youth in general significantly affected the quality of the parent-child relationship. They stated, “If parental support decreases after an adolescent’s first sexual activity, this loss of support might well place the youth at risk for a downward spiral in which problem behavior increases as supports fall away.” (p. 171) In the context of juvenile sexual offending, rather than these children experiencing a loss of parental support due to sexual activity, many never had the support of their parents to begin with (Ream & Savin-Williams) and their sexual activity, once known, further precludes any parental allegiance (Barbaree & Langton, 2006).

Caregiver Inconsistency

One variable common to the parenting of sexual offenders includes caregiver inconsistency (McCormack et al., 2002). Though not all JSOs are in the foster care system, it is not uncommon for those who are to experience serial foster homes, where caregiver inconsistency rises exponentially due to the differences between caregiver rules (Owenby et al., 2001). While there is sparse mention in the literature of differences between foster care and family of origin in terms of sex education and/or rules regarding sexual behavior or enforcement of these rules, Browne and Lynch (1999) summarized the literature on public care available at that time by mentioning that children entering into the foster care system had already experienced some mental difficulties, were more likely to show criminal and delinquent behavior in relation to other children, suffered greater health and educational difficulties, experienced a stigma associated with no longer being

with their families, and felt a sense of abandonment, lack of continuity in relationships, and a generalized sense of bewilderment. Browne and Lynch found that 40% of those in public care in 1998-1999 had been in foster care for less than eight weeks. Furthermore, children placed in foster care sometimes experienced additional abuse and/or bullying, some of which was in the sexual realm, some of which may have placed them more at risk in general for both offending and being offended on, both physically and sexually.

Another form of caregiver inconsistency is found through the absence of a parent (Marshall & Eccles, 1993). Owenby et al. (2001), in a study of six clients, stated:

> Over half of the juvenile sexual offenders were found to have experienced some form of parental loss through death, divorce or separation. Sexual offenders may be less likely than nonsexual offenders to have an intact family of origin and this fact may be partly responsible for their subsequent interpersonal problems. (p. 86)

Violence/Anger Regulation

The families of JSOs often have high rates of conflict (Barbaree & Langton, 2006). Concepcion (2004) found that typically, younger offenders experience even greater family violence than those who begin offending as older teens, lack positive anger management skills, have blurred boundaries regarding privacy, and have parents who seem unable to cope with the abuse their children have committed. Howes and colleagues (2000) looked at the relational characteristics of maltreating families, describing the families in their study as having “victim-victimizer roles, in which abused children may become the abuser with peers, suggesting that they have internalized both roles of the abusive relationship.” (p. 96) This is often the case with JSOs if they “work out their own abuse” through abusing others (Barbaree & Langton).

Secrecy

Baker, Tabacoff, Tornusciolo, and Eisenstadt (2003) hypothesized that because sex offending has at its core an element of secrecy, juvenile sex offenders would have more family secrets in general than the families of non-sex offending children. The results of their study indicated that "families of juvenile sex offenders told more lies, had more family myths, and [were] more likely to be involved in taboo behavior" (Baker et al., p. 105).

Father Involvement

In addition to chaotic family structure, the role of fathers has become a subject of research (Bischof et al., 1992). In the early years of research with juvenile sex offenders, it was assumed that the primary parental relationship of importance was that with mothers (Bischof et al.). However, as further studies were conducted, results indicated that father-child relationships were also of great significance (Bischof et al; Smith et al., 2005); adolescent sex offenders have "a history of abandonment, first by fathers, and later by mothers for crucial periods" (p. 319). In a study of 85 male sexual offenders compared to two non-sexual offending criminal comparison groups (30 violent offenders and 32 nonviolent men, respectively), McCormack et al. (2002) stated:

> Traditionally, the role of the father in the etiology of an individual's sexual offending is seen as insignificant. This perspective may have originated from the absence and lack of involvement of fathers in the early upbringing of many sexual offenders. However, the picture appears to be more complex than these results suggest. Of those sexual offenders who reported a father present during their childhood, the relationship between the father and the individual concerned was typically described as more problematic and negative than that between mother and son. Specifically, a large percentage of sexual offenders (57%) described their fathers as

> cold, distant, hostile, and aggressive, with fewer (18%) crediting their fathers with positive qualities such as warmth. This negative perception may be related to the high rates of physical abuse inflicted by both biological fathers and stepfathers on sexual offenders. (pp. 85-86)

McCormack and colleagues (2002) suggested that the fathers of these children play a significant role in the development of sexual aggression, whether this is through their lack of involvement or through the violence that they often perpetrate on others, whether another parent, child, pet, or inanimate objects. McCormack and colleagues further stated that 57% of sexual offenders described their fathers as cold, distant, hostile, and aggressive. A large percentage of these fathers and step-fathers were reported to be physically abusive (McCormack et al.).

In Hunter's 2004 study, more than 75% of his sample of 182 adult male sex offenders had been exposed to some form of sexual or physical violence toward females; over half had witnessed a male relative beat a female, almost half had witnessed a male relative threaten another male with a weapon, and almost 60% had seen a male relative commit a nonviolent crime such as selling drugs. Over 90% of the sample had been exposed to some form of male-modeled antisocial behavior such as domestic violence, dating violence, control of women, criminal activity, and so forth.

Hunter (2004) suggested that his results indicated that when children observe females being physically and/or sexually abused, there are direct and indirect effects on nonsexual aggression and delinquency. Further, these children become sensitized to others' sexual advances toward desired females and in the heat of the moment see aggression as the best option for addressing these perceived threats (Hunter). Hunter stated that his study lends credence to the idea that exposure to violence against women

may nurture harmful attitudes regarding females; exposure to violence expands the value of dominance and aggression and may also promote deficiencies in understanding and acquisition of prosocial relationship skills. “The finding of a direct effect for exposure to male-modeled antisocial behavior on delinquency is consistent with the belief that young males are vulnerable to internalizing the values and imitating the behavior of socially deviant peers and adults” (Hunter, p. 239).

Although the connection between these ideas and juvenile sexual offending has not been clearly evidenced in the research, it has been demonstrated that they play a large part in adult male offending (Hunter, 2004). It is logical to hypothesize, although not conclude, that adolescent males who experience these kinds of modeling behaviors from fathers and stepfathers may be more likely to use similar behaviors. White, Kadlec, and Sechrist (2006) stated that societal norms of general violence influence and contribute to sexual aggression and objectification of women.

In summary, the literature describing the family characteristics of juvenile sex offenders indicates that JSO families tend to be chaotic, maltreating, and inconsistent in parental support. In these families, there is often a greater amount of secrecy and anger issues, and father involvement is often seen in a negative role-model position. These families also often display boundaries that are either too rigid or very poorly defined. The intent of the current study was to determine whether the current sample was similar to or different from those described in the literature, and whether information about the sample adds new information to the literature.

Limitations to Prior Research

It is remarkable to the author that very little has been mentioned in the literature about both culture and race. Ethnicity is demarcated within the samples of studies, but rarely referred to in discussion sections. In addition, there appear to be few assessment measures deemed reliable and accurate for use with juvenile sex offenders or for persons who are other than Caucasian. There are few empirical studies done with JSOs at all, making it difficult to describe (a) the range of characteristics of youth in this population, (b) the relationships within which juvenile sex offending behaviors develop, (c) the cultural contexts within which JSOs develop identity and sexual behaviors, and (d) the complexity of interactions among sexual offending, other types of difficult behavior, and victimization of the youth themselves. The literature describes a number of factors and variables that correlate with juvenile sex offending, but few have examined these as a whole. Furthermore, these studies have not looked at these factors from the vantage point of era (are there more or fewer of these variables present currently than there were five or ten years ago?), nor do they look at the ages of the juveniles when assessing for these variables (do younger JSOs present with greater or fewer of these variables than their older counterparts?). This study aimed, in part, to rectify this by providing a thorough description of a particular sample of sexually offending youth who received treatment in residential care.

Purpose of Study and Research Questions

The purpose of this study was to examine a combination of variables related to

contextual factors of JSOs in the study sample. The objective was to analyze extant data relative to these factors. The specific research questions included:

1. How was this sample described in terms of the following variables: sexual abuse, early exposure to sexuality, conduct disorder problems, exposure to crime in the family of origin, personal substance abuse, family substance abuse, school performance difficulties, school behavior problems, mental health difficulties, social skills deficits, changes in family structure, and non-sexual forms of abuse?
2. Were there any differences among variables with respect to facilities?
3. Were there any differences among variables with respect to race?
4. Were there any differences among variables with respect to the years admitted for treatment?
5. Were there any differences among variables with respect to client's age at admission?
6. Were there any statistically significant correlations among the study variables?

Data gathered from initial assessments were analyzed so that the sample could be described and so that possible relationships among the study variables could be examined.

CHAPTER III

METHODS

Design

This study was designed to be an exploratory study, which utilized secondary analysis of retrospective data gathered from the initial assessments of 124 de-identified male juvenile sex offenders from two level six residential treatment centers: Youthtrack-Utah, Brigham City and Youthtrack-Utah, Logan between the years of 1998 and 2007. The following variables were described within the sample: victims of sexual abuse, exposure to early sexuality, victims of other forms of abuse, frequent family structure changes, conduct disorder issues, exposure to crime in the family of origin, personal substance abuse, exposure to family substance abuse, school performance difficulties, school behavior problems, mental health difficulties, and social skills deficits.

Sample

The sample for this study consisted of 124 males who were admitted to one of two level six RTCs spanning the years from 1998 to 2007. Level six treatment is demarcated by residential treatment that is separated by sex (male or female); often, but not always, court-mandated; and focuses on but is not limited to sexual behavior. According to NOJOS (Gourley et al., 2007), JSOs who should be assigned to level six treatment are:

> . . . higher-risk youth who engage in sexual misconduct with a broad range of sexual-offense behaviors and who are often sexually-preoccupied.

> These youth have serious and significant sexual acting out issues, potentially highlighted by being patterned and repetitious behaviors. They may have persistent or fixated patterns of offending, use of force or weapons in committing their offenses, and/or a display a propensity to act out with same-aged peers in addition to their younger victims. These are youth with multiple vulnerabilities and deficits in their ability to meet their needs and obtain human goods (i.e., healthy living, knowledge, excellence in play and work, excellence in self agency, freedom from emotional turmoil and stress, friendship, community, purpose in life, happiness and creativity. (Gourley et al., p. 39)

The RTCs–Youthtrack-Utah, Logan and Youthtrack-Utah, Brigham City–are similar in their treatment philosophies and programs, differing only in the functional level of the clients. According to Kevin Barlow, LMFT, the director of treatment at Youthtrack-Utah, the Logan facility was geared toward low-functioning clients (IQs 60 - 90). No clients were admitted with an IQ lower than 60. Those who received treatment in the Brigham City facility had average functioning levels. In addition to lower functioning clients, those who were younger or who were unusually small in stature were usually assigned to the Logan facility in an effort to "keep the playing field equal" and not place them at risk from the older, larger boys (K. Barlow, personal communication, June 30, 2007). The all-male sample selected for inclusion in this study consisted of residents who were admitted to one of the Youthtrack RTCs between the years of 1998 and 2007.

Demographic Data

The sample from both Youthtrack-Utah RTCs included primarily Caucasians, with some Hispanic, African American, and mixed and unknown races represented (see Table 1). Of the sample, 45% of the males were from the Brigham City RTC and 55% were from the Logan RTC. The ages of clients ranged from 11 to 18 years of age.

Table 1

Frequencies: Age and Race by Center

	Brigham City Center		Logan Center		Total	
Variable	*n*	%	*n*	%	*n*	%
Race						
Caucasian	44	77	54	82	98	79
Hispanic	7	12	7	10	14	11.3
African American	2	4	4	6	6	4.8
Mixed Ethnicity/unavailable	4	7	2	3	6	4.8
Total	57	45	67	55	124	100
Age						
11	1	2	2	3	3	2
12	5	9	7	10	12	10
13	8	14	20	30	28	23
14	20	35	14	21	34	27
15	7	12	10	15	17	14
16	10	17	9	13	19	15
17	5	9	4	6	9	7
18	1	2	1	2	2	2
Total	57	100	67	100	124	100

Note. $N = 124$, n(Brigham City Center) = 57, n(Logan Center) = 67.

Age at admission ($M = 14.23$).

Data Collection

Data were collected from the initial assessments found within the clients' files. These assessments were a compilation of information available to Youthrack-Utah in an effort to provide as much information as possible regarding client demographic information, prior living arrangements, reason for referral, social history (psychosocial functioning), demographics of the youth's larger system (family, peers, community), legal history with current criminal charges, previous medical and psychiatric history, family psychiatric and substance abuse history, past and current drug and alcohol history, level of self care, an educational history and current assessment, mental status exam, a sexual behavior inventory, a DSM-IV-TR diagnosis, and psychiatric recommendations.

Common sources of information included but were not limited to client report; police reports; interviews with the client and related professionals and parents; documents provided by case workers and social services; court documents; psychologist reports; official assessments such as MMPI-A (Hathaway & McKinley, 1940), the BDI (Beck et al., 1961), the Y-OQ (Burlingame et al., 1996), the SAI-J (Lindeman, 2005), and assessments on scholastic abilities such as the Woodcock-Johnson Psychological Battery (Woodcock et al., 2001).

Over the course of the first month at Youthtrack-Utah, the client's primary therapist spends at least four hours with the client in individual interviews, and multiple hours observing and interacting with the youth in both treatment groups and multi-family group therapy. Self-revealed information that is pertinent is added to the information from other sources in the creation of this initial assessment. Calls may be made to parents

or caseworkers to clarify or answer questions that the therapist might have regarding the client's history in any of the previously mentioned areas. All information is then compiled into one document and placed in the client's chart. See Appendix A for the standards for completing the initial assessment according to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards, which the therapists used as a resource to inform their questions during the course of the interviews and in the formation of the initial assessment for data used for this study.

It should be noted that a "yes" on the variable checklist was inferred from the information gained throughout interviews. The questions utilized by therapists are not designed to obtain a "yes" or "no" answer, but rather, are indended to facilitate discussion between clients and therapists and encourage open dialog. These assessments are designed for state and federal commissions for use with their yearly audits, and are based on their own assessment forms.

Instrument

Although the initial assessments were created by various therapists, the data gleaned from these assessments for this study were collected by one individual after the data were de-identified. The clinical director of the Youthtrack programs, Kevin Barlow, LMFT, gave permission to use his data (see Appendix B) and then developed a data-gathering form (see Appendix C) on which he recorded the data from the client's charts. Specific information is described next.

De-identified data were received and put into SPSS. Collateral reports were

indicated when a person other than the Youthtrack-Utah client confirmed the variable in question. Such people included but were not limited to case workers, teachers, school counselors, those working within the legal and judicial system, parents, foster parents, staff from previous placements, and persons involved with the medical and psychiatric fields. The clinical director of Youthtrack-Utah entered data as "yes" if information suggested a presence of the factor. If there was no information, the cell was left blank.

Victims of Sexual Abuse

In the data collection for this study, a variable was marked "yes" to past sexual abuse per client report. This report was corroborated by one outside source.

Early Exposure to Sexuality

Early exposure to sexuality includes chronic use of pornography, unregulated media influences, and open sexuality among adults. In the data collected for this study, a variable was marked "yes" to early exposure to sexuality if, as the therapist interviewed the client or by collateral report, it was evidenced that the client had been exposed to the above-mentioned forms of sexuality. Because these clients were all minors, any exposure prior to their offense was considered "early." Questions that guided therapists as they looked at documents, interviewed youths, parents, or caseworkers included but were not limited to (a) what are the client's first memories of sexual experiences?, (b) what sexual behaviors were observed in the home and community?, (c) what family boundaries surrounding sexuality and modesty are described?, (d) how was sexuality discussed in the home?, (e) what rules regarding media and sexual influences were in the home?,

(f) where did the client gain access to pornography, if relevant?, (g) what consensual sexual experiences does the client report?, (h) does the client or referral agency report that the client sexually acted out while in a treatment or correctional placement?, (i) does the client report any behavior that may indicate a fetish or paraphilia?, and (j) what types of sexual fantasies and urges does the client report experiencing recently?

Victims of Other Forms of Abuse or Neglect

A variable was marked "yes" to forms of abuse or neglect other than sexual per client report and corroborated by one outside source. Outside sources might include statements by someone such as the caseworker, e.g., "client reported that his mother often beat him with a metal bar when she became angry."

Frequent Family Structure Changes

A variable was marked "yes" to frequent family structure changes if the client or collateral report revealed multiple changes in the client's family structure or at least one family structure change every two years. Examples of this might include parental divorce, separation, remarriage, or boyfriend/girlfriend of parent moving into or out of the home; siblings or step-siblings moving in or out of the home; or a death of a parent.

Conduct Disorder Problems
Other Than Sexual Offending

A variable was marked "yes" to conduct disorder behavior other than sexual offending through the DSM-IV-TR diagnoses, client report, or collateral reports. Information may have come through legal history, client report over the four-week

assessment period, or reports from medical charts, caseworkers, parents, police, or others involved with the youth, for example, "the caseworker reports that the client was arrested for shoplifting two years prior to enrollment in the RTC."

Exposure to Crime in the Family of Origin

A variable was marked "yes" to exposure to crime in the family of origin if the client or anyone in the client's family committed at least two episodes of crime against people or property. The referral packet often provided this information via the social worker and the Department of Child and Family Services. Sometimes, parents are in jail for crimes such as drug use or distribution or assault of someone outside of the family.

Personal Substance Abuse

In the data collection for this study, a variable was marked "yes" to personal substance abuse if the client experienced a pattern of alcohol or drug use that interfered with educational, occupational, or social functioning that was reported by parents, educators, social workers, or the client. Questions to help guide the therapist's interview, in which this information might be revealed, included (a) has the client used alcohol, tobacco, illicit drugs, chemicals, inappropriate use of prescription drugs (either theirs or someone else's), or over-the-counter medications for inappropriate purposes?, (b) has the client ever passed out or had significant experiences such as hallucinations with substances?, (c) has the client ever experienced any symptoms of dependency or withdrawal?, and (d) has the client ever been in treatment for substance use?

Exposure to Family Substance Abuse

Exposure to family substance abuse was defined by one or more members in the family structure using alcohol or drugs in a manner that interfered with the individual's functioning. This variable was marked "yes" per client, parental, caseworker, or police report. A question to help guide the interview was, "What is known about the immediate and extended family's substance use history, including legal or treatment complications?"

School Performance Difficulties

School performance difficulties were defined by a chronic history of poor or failing grades. In the data collection for this study, a variable was marked "yes" to school performance difficulties if the client's academic records showed poor or failing grades for several years in a row or were reported as such by educators. Questions to help guide the therapist's interview to assess for school performance difficulties included (a) what is known about the client's educational history and performance?, and (b) what does the client report in regard to schooling, his strengths, and his weaknesses?

School Behavior Problems

A variable was marked "yes" to school behavior problems such as truancy, fighting, or chronic cheating or other repeated behavior problems if these were reported by parents, caseworkers, educators, or clients. However, the severity of such were not noted.

Mental Health Difficulties

Mental health difficulties for the purposes of this study were defined by

symptoms or diagnoses of depression, anxiety, or other mental health difficulties, including (but not limited to) ADHD, bipolar disorder, schizophrenia, psychosis, and so forth. In the data collection for this study, a variable was marked “yes” to mental health difficulties if the client had a history of mental difficulties, was assigned a DSM-IV-TR diagnosis by a clinician or psychiatrist, or from statements per client report such as, “I feel depressed” or, “I feel like killing myself.” Also taken into consideration were the results from tests such as the BDI-Y (Stapleton, Sander, & Stark, 2007). Questions to help guide the therapist’s interview included (a) how relaxed or nervous does the client appear?, (b) did the client appear to understand the questions posed?, (c) did he sit still or was he more active?, (d) did the client take responsibility or was he evasive, blaming, or denying?, (e) was the client able to answer the questions fully and in an understandable manner?, (f) did the client display paranoia or other concerning thoughts?, (g) was the client able to respond in an efficient manner or did there appear to be a cognitive deficit?, (h) how did the client describe his mood during the assessment?, (i) were observations consistent with his report?, (j) in what way did the client’s affect vary during the assessment, (k) were the variations consistent with the topics being discussed?, (l) did the client appear to be able to display a variety of emotions or did he seem restricted in any way?, (m) was the client oriented to person, time, and place?, (n) does the client’s memory appear to be intact?, (o) does the client have any desire to harm any individuals at this time?, (p) does the client have a history of suicidal attempts or ideation?, (q) what are the current DSM-IV-TR diagnoses?, and (r) what psychotropic medications is the client currently taking?

Social Skills Deficits

Social skills deficits were defined by a history of few same-aged friends and/or social isolation. A variable was marked "yes" to social skills deficits if this was reported by client or collateral reports. Questions to help guide the therapist's interview included (a) what do the caregivers report in regard to early socialization and attachment?, (b) what does the client report in regard to his friendships and social status?, (c) was the client a bully or loner; was he picked on?, (d) what do the referrals and caregivers report in regard to the client's social maturity and functioning?, (e) what is the client's history of emotional and behavioral functioning?, and (f) what is the history of maladaptive or problematic behaviors?

CHAPTER IV

RESULTS

Analyses

The data were entered into SPSS (Nie, Bent, & Hull, 1968) and described by frequency. Data analyses provided a means to compare the variables in terms of frequencies and to look for commonalities and differences. The samples from the Logan and Brigham City facilities were combined so that variables could be looked at as a whole and then later, data were separated and chi-square tests were performed by site, race, and the date of admission (the first five years of data were compared to the last five). Results are reported in descriptive form for each research question in the results chapter of this thesis. In addition, Pearson's correlations were computed for each pair of variables. The findings are discussed in relation to the current literature on JSOs, as well as discussions of future research that the findings suggest may be of value.

Research Question One: How Is This Sample Described According to Variable?

The initial research question focused on a description of the sample in terms of factors related to the following: sexual abuse, early exposure to sexuality, conduct disorder problems, crime in the family of origin, personal and family substance abuse, school behavior problems and performance difficulties , mental health difficulties, social skills deficits, changes in family structure, and nonsexual forms of abuses (Table 2).

Table 2

Positive Endorsements of Variables, Total Sample

Variable	*n*	%
Victim of sexual abuse (VSA)	75	60.5
Early exposure to sexuality (EES)	44	35.5
Victims of other forms of abuse and neglect (VNA)	78	62.9
Frequent family structure changes (FFS)	54	43.5
Conduct disorder (other than sexual) (CD)	76	61.3
Exposure to crime in the family of origin (EC)	31	25.0
Personal substance abuse (PSA)	33	26.6
Exposure to family substance abuse (FSA)	63	50.8
School performance difficulties (SPD)	72	58.1
School behavior problems (SBP)	63	50.1
Mental health difficulties (MHD)	92	74.2
Social skills deficits (SSD)	64	51.6

Note. $N = 124$.

Research Question Two: Were There Any Differences Among Variables With Respect to Facilities?

Cross-tabulations were calculated between the two facilities on all of the variables and chi-square analyses were conducted. Four variables showed statistically significant differences, each found in greater than expected frequencies within the Logan RTC: FFS, SPD, MHD, and SSD (see Table 3).

Table 3

Significant Chi-Square Tests of Study Variables by Facility

Variable	χ^2	Logan Expected (actual)	Brigham City Expected (actual)
VSA[a]	0.83	40.5 (43)	34.5 (32)
EES[b]	1.48	23.8 (27)	20.2 (17)
VNA[c]	3.28	42.1 (47)	35.9 (31)
FFS[d]	6.15	29.2 (36)	24.8 (18)
CD[e]	0.00	41.1 (41)	34.9 (35)
EC[f]	0.01	16.8 (17)	14.3 (14)
PSA[g]	0.12	17.8 (17)	15.2 (16)
FSA[h]	0.54	34.0 (32)	29.0 (31)
SPD[i]	4.96	38.9 (45)	33.1 (27)
SBP[j]	0.50	34.0 (36)	29.0 (27)
MHD[k]	11.66**	49.7 (58)	42.3 (34)
SSD[l]	16.95**	34.6 (46)	29.4 (18)

Note. $N = 124$; $df = 1$; n(Logan) = 67; n(Brigham City) = 57.

[a] (VSA) = Victims of Sexual Abuse, [b] (EES) = Exposure to Early Sexuality, [c](VNA) = Victim of Non-sexual Abuse, [d] (FFS) = Frequent Family Structure Changes, [e] (CD) = Conduct Disorder, [f] (EC) = Exposure to Crime in the Family of Origin, [g](PSA) = Personal Substance Abuse, [h] (FSA) = Family Substance Abuse, [i](SPD) = School Performance Difficulties, [j] (SBP) = School Behavior Problems, [k](MHD) = Mental Health Difficulties, [l] (SSD) = Social Skills Deficits.

**$p \leq .001$.

Research Question Three: Were There Any Differences Among Variables With Respect to Race?

The sample for this study was primarily Caucasian (*n* = 98, 79%). For the purposes of comparing ethnicities, an “other” category was created by combining Hispanic (*n* = 14; 11.3%), Black (*n* = 6; 4.8%), and Other/unknown (*n* = 6; 4.8%) into one grouping. When cross-tabulation analyses were performed on these two groups (Caucasian and Other) for the variables of interest, most did not show any statistically significant differences. However, two variables did show significance between clients who were Caucasian and those who were not: the ‘Other’ sample showed greater conduct disorder, other than sexual offending ($\chi^2 = 7.54$, $p \leq .01$) and personal substance abuse ($\chi^2 = 9.21$, $p \leq .01$; See Table 4).

Research Question Four: Were There Any Differences Among Variables With Respect to Years Admitted for Treatment?

Data were collected between the years of 1998 and 2007. The data were split into two groups (1998-2002 and 2003-2007) and chi-square tests were performed to see if there were any appreciable differences between these two groups, hypothesizing that perhaps data collection procedures had differed, or perhaps the levels of variables for JSOs differed appreciably between these years. The earlier era group (1998-2002) showed significantly greater levels of early exposure to sexuality, ($\chi^2 = 9.60$, $p \leq .01$), conduct disorder, other than sexual offending ($\chi^2 = 4.82$, $p \leq .01$), and personal substance abuse ($\chi^2 = 6.83$, $p \leq .01$; See Table 5).

Table 4

Significant Chi-Square Tests of Study Variables With Respect to Race

Variable	χ^2	Caucasian Expected (actual)	Other Expected (actual)
VSA[a]	0.33	59.3 (58)	15.7 (17)
EES[b]	0.67	34.8 (33)	9.2 (11)
VNA[c]	0.09	61.6 (61)	16.4 (17)
FFS[d]	0.35	42.7 (44)	11.3 (10)
CD[e]	7.54*	60.1 (54)	15.9 (22)
EC[f]	0.07	24.5 (25)	6.5 (6)
PSA[g]	9.21*	26.1 (20)	6.9 (13)
FSA[h]	0.12	49.8 (49)	13.2 (14)
SPD[i]	0.16	56.9 (56)	15.1 (16)
SBP[j]	0.62	49.8 (48)	13.2 (15)
MHD[k]	0.42	72.7 (74)	19.3 (18)
SSD[l]	3.81	50.6 (55)	13.4 (9)

Note. $N = 124$. $df = 1$; n(Caucasian) = 98; n(Other) = 26.

[a] (VSA) = Victims of Sexual Abuse, [b] (EES) = Exposure to Early Sexuality, [c](VNA) = Victim of Non-sexual Abuse, [d] (FFS) = Frequent Family Structure Changes, [e] (CD) = Conduct Disorder, [f] (EC) = Exposure to Crime in the Family of Origin, [g](PSA) = Personal Substance Abuse, [h] (FSA) = Family Substance Abuse, [i](SPD) = School Performance Difficulties, [j] (SBP) = School Behavior Problems, [k](MHD) = Mental Health Difficulties, [l] (SSD) = Social Skills Deficits.

* $p \leq .01$.

Table 5

Significant Chi-Square Tests of Study Variables With Respect to Years of Data Collection

Variable	χ^2	1998-2002 Expected (actual)	2003-2007 Expected (actual)
VSA[a]	0.30	40.5 (42)	34.5 (33)
EES[b]	9.60*	23.8 (32)	20.2 (12)
VNA[c]	1.13	42.1 (45)	35.9 (33)
FFS[d]	0.44	29.2 (31)	24.8 (23)
CD[e]	4.82	41.1 (47)	34.9 (29)
EC[f]	1.83	16.8 (20)	14.3 (11)
PSA[g]	6.33	17.8 (24)	15.2 (9)
FSA[h]	1.14	34.0 (37)	29.0 (26)
SPD[i]	0.16	38.9 (40)	33.1 (32)
SBP[j]	0.50	34.0 (36)	29.0 (27)
MHD[k]	3.12	42.3 (38)	49.7 (54)
SSD[l]	2.54	34.6 (39)	29.4 (25)

Note. $N = 124$. $df = 1$; $n(1998\text{-}2002) = 67$; $n(2003\text{-}2007) = 57$.

[a] (VSA) = Victims of Sexual Abuse, [b] (EES) = Exposure to Early Sexuality, [c](VNA) = Victim of Non-sexual Abuse, [d] (FFS) = Frequent Family Structure Changes, [e] (CD) = Conduct Disorder, [f] (EC) = Exposure to Crime in the Family of Origin, [g](PSA) = Personal Substance Abuse, [h] (FSA) = Family Substance Abuse, [i](SPD) = School Performance Difficulties, [j] (SBP) = School Behavior Problems, [k](MHD) = Mental Health Difficulties, [l] (SSD) = Social Skills Deficits.

* $p \leq .01$.

Research Question Five: Were There Any Differences Among Variables With Respect to Client's Age at Admission?

The individuals within this sample ranged in age from eleven to eighteen years upon admission to the Youthtrack treatment facilities when the initial assessments were created from which the data for this study were collected. The variables of interest were cross-tabulated with the ages of the sample at the time of data collection to see whether there were any significant differences among them. None of the chi-square tests reached statistical significance.

Research Question Six: Were There Any Statistically Significant Correlations Among the Study Variables?

The variables of interest were correlated using Pearson's correlations (2-tailed) to investigate statistically significant relationships. Many of the variables showed relationships among them and are reported below as well as in Table 6. The following variables correlated at the $p \leq .01$level with $r \geq .243$: frequent family structure changes with victims of sexual abuse and victims of non-sexual abuse; personal substance abuse with conduct disorder; family substance abuse with conduct disorder and personal substance abuse; school performance difficulties with school behavioral problems; school behavioral problems with conduct disorder, school performance difficulties, and family substance abuse; social skills deficits with mental health difficulties (see Table 6).

Table 6

Correlations of the Variables of Interest

	VSA[a]	EES[b]	VAN[c]	FFS[d]	CD[e]	EC[f]	PSA[g]	FSA[h]	SPD[i]	SPB[j]	MHD[k]
VSA[a]	--										
EES[b]	-.125	--									
VAN[c]	.165	.046	--								
FFS[d]	.244*	.130	.371*	--							
CD[e]	.069	.001	.007	-.070	--						
EC[f]	.086	.000	.135	.207	.191	--					
PSA[g]	.002	.027	-.029	.097	.404*	.158	--				
FSA[h]	.162	.055	.146	.214	.245*	.307*	.264	--			
SPD[i]	.049	.118	.092	.021	.130	.-038	.105	.243*	--		
SPB[j]	.096	.022	.213	.051	.344*	.084	.264*	.266*	.504*	--	
MHD[k]	.089	-.025	.043	-.002	-.128	-.043	-.145	-.064	.022	.046	--
SSD[l]	.076	.111	.125	.069	-.107	-.075	-.220	-.017	.158	.112	.314*

Note. [a] (VSA) = Victims of Sexual Abuse, [b] (EES) = Exposure to Early Sexuality, [c](VNA) = Victim of Non-sexual Abuse, [d] (FFS) = Frequent Family Structure Changes, [e] (CD) = Conduct Disorder, [f] (EC) = Exposure to Crime in the Family of Origin, [g](PSA) = Personal Substance Abuse, [h] (FSA) = Family Substance Abuse, [i](SPD) = School Performance Difficulties, [j] (SBP) = School Behavior Problems, [k](MHD) = Mental Health Difficulties, [l] (SSD) = Social Skills Deficits.

* $p \leq .01$.

CHAPTER V

DISCUSSION

Although research of JSOs often takes a linear form, studying one variable and its effects on juvenile sex offending, treatment frequently employs a more systemic approach (Hunter, 2000), taking into account the varied factors that may have influenced and impacted a JSO's life and experience, and therefore, his rehabilitation success. In looking at data for 12 different common factors of JSOs, it is worth noticing not only how these factors appear individually, but also asking questions about how they may interact or affect one another within the life of JSOs.

Current studies tend to focus on individual variables and JSOs, such as the relationship between criminal activity and juvenile sex offending (Wijk, Mali, Bullens, & Vermeiren, 2007), but little contemporary research compares multiple variables as this study does. This could be, in part, because many of these factors are accepted components of the overall profile of JSOs, or studies possibly are limited in the number of variables because of the complexity of interpreting such data.

The information gleaned from this study of analysis of the Youthtrack-Utah data is helpful in that it lends credence to information from previous studies by demonstrating similar findings. However, in revealing similar findings, there is a sense of disappointment in the lack of new insights into JSO populations. Following, the various research questions and results are discussed and compared to current literature, as well as discussed in terms of implications for future research, policy, and treatment of JSOs.

Research Question One: How Is This Sample Described According to Variable?

Sexual Abuse

Although none of the literature indicates that sexual abuse causes sexual offending, noting that some children who are sexually abused do not sexually offend on others, still, it is worth drawing attention to the fact that high percentages of JSOs in this sample were sexually abused (60%). This is consistent with the current literature (Barbaree & Langton, 2006; White et al., 2006). Barabee and Langton noted that problematic sexual behaviors in children are often precursors to abusive sexual behaviors in adolescence and that the vast majority of children who exhibit problematic sexual behaviors as children have been victims of sexual abuse. White et al. stated that their review of the literature of adolescent acquaintance sexual offending indicated that sexually assaultive adolescents have a higher rate of sexual abuse themselves than their non-assaultive counterparts and that it was rational to suggest that their problematic behaviors are derived from childhood experience.

Barbaree and Langton (2006) described a 1995 study of 1,268 JSOs in the extant literature; of these, 31% reported some form of sexual abuse, which was triple that of men in the general population. In the current sample, 60% demonstrated victimization of sexual abuse, twice that of the 1995 study. The author wonders if this figure of victimization is, in fact, even larger, due to the fact that the data were gathered from initial assessments; more information may have been gleaned had the whole case file been analyzed because sexual abuse often is disclosed after several months of treatment.

Furthermore, the author wonders whether the rate of sexual abuse is rising, whether reporting has increased, or both.

Early Exposure to Sexuality

The results in this study yielded what seemed to the author to be low numbers (35.5%) of exposure to sexuality based on the opinion of those involved in treatment of JSOs who state that they believe that the vast majority of youth see pornography at some point in their childhoods (K. Barlow, personal communication, Aug 30, 2007). According to Ybarra and Mitchell (2005) a national survey of older teenagers revealed that the teens felt viewing internet pornography influenced adolescents to have sex earlier and almost one in two respondents indicated that they felt viewing pornography encouraged negative attitudes toward women. Both of these factors could be antecedents to juvenile sex offending. Ybarra and Mitchell stated that the ethical issues concerned with actively showing adolescents pornography for the sake of research, there have been no clinical studies done on this subject; however, understanding the perceptions and beliefs of teenagers is helpful in informing possible avenues of future study related to this topic. As more studies are conducted utilizing retrospective data relating to the topic of early exposure to sexuality, it is possible that there will be greater illumination as to the nature of if /how early exposure to sexuality is systemically related to juvenile sex offending.

It is possible that information gathered from the complete client file rather than the initial assessment exclusively would have yielded higher numbers. Based on her experience in Youthtrack-Utah, the author suggests that the youths were rarely

completely forthcoming at the time of their initial assessments, especially with matters concerning their offenses, pornography, and the sexual practices of their caregivers. Furthermore, currently, there are no clear definitions as to what pornography is or is not. Over the course of their treatment, boys who previously denied having seen pornography would say in group, “Oh yeah, I saw that kind of stuff all the time.” During the initial assessment time, the way that youth were asked about their experiences apparently affected their understanding of the question. That is, their understanding of pornography may have not included experiences they had had that would be considered pornographic by others.

It seems plausible to hypothesize that early exposure to sexuality has some effect on youth, though the extent of this effect is unknown. As with sexual abuse, one cannot say that early exposure to sexuality causes sex offending. However, because it is in the backgrounds of many JSOs, one also cannot say that exposure to sexuality is immaterial. Malamuth et al. (2000) noted the presence of individual differences (strengths or weaknesses; resources or lack of resources) moderated pornography’s effect on adult men; they were not equally affected. It is possible that by virtue of their youth, JSOs may not possess the necessary factors to moderate pornography’s influence on them, and therefore, they are more susceptible to its negative effects, whether sexual aggression or desire to try ideas they see presented in the sexually explicit material.

One could hypothesize about the interplay of these variables: youth with frequent changes in their family structure or those that possess lower functioning may live in families where overall stress may prevent healthy parental monitoring of sexually explicit

materials. Parents who are incarcerated or impaired by drug use or other problems are not available to set limits on computer use. Parents who were raised with no values or limits set on sexually explicit material may not think to set limits on these materials, because they were exposed to them as children and they "turned out all right."

Nonsexual Forms of Abuse

Seventy-eight of the total sample (62.9%) demonstrated victimization of other forms of abuse and neglect. This is corroborated by the literature as an associated variable of juvenile sex offending (Smith et al., 2005). Abuse in all its forms is commonly referred to as a variable of juvenile sex offending (Smith et al.), though few actual studies have been conducted with respect to this variable in the recent past, perhaps because it has already been established as a known common factor. As with other variables in this study, questions regarding their interplay must be asked. It seems plausible to consider that parents who are under the influence of drugs or alcohol are potentially more likely to commit acts of abuse upon their children than those parents who are not under the influence substances. Similarly, the stress of frequent situational changes in family structure (divorce, death, remarriage) may make parents more prone to lash out in anger or frustration. Lower functioning in terms of intelligence either on the part of the parent or the child or both may also lend predilections toward abuse (Masi, Marcheschi, & Pfanner, 1998).

Frequent Family Structure Changes

Fifty-four of the total sample (43.5%) demonstrated frequent family structure

changes defined by the client's having experienced at least one family structure change every two years, such as parental divorce, separation, remarriage, or boyfriend/girlfriend of parent moving into the home; siblings or step-siblings moving in or out of the home; or a death of a parent. It should be noted that the issue being addressed within this variable is not the structure per se, but rather the continuity of it. A youth who comes from a single-parent household that stays consistent in this status would not be marked for frequent family structure changes. However, a change involving a single parent who then remarries and then divorces would be marked as such, even though the youth is returning to what he had experienced previously.

Many studies have looked at issues surrounding divorce with varying results; some seem to indicate that divorce is harmful to children and some that children appear to adjust after a time (Hudson, McCormack, & Ward, 2002). However, the majority of the literature suggests that, at least at the time of the divorce, stress is high and children seem disrupted. Overall functioning appears to drop (Center for Disease Control, 2008b). One would assume from this that continuity is important to children. For JSOs, frequent changes in family structure, regardless of the reason, adds a layer of stress into their experiential system, which, if already stressed might be enough to erode other protective factors that prevent juvenile sexual offending, such as parental supervision or the nurturing required to overcome traumatic experiences such as sexual abuse. Further, these family structure changes may introduce an outsider such a step-father or step-brother who might perpetrate abuse (physical, sexual, or emotional) onto the pre-JSO, which might be the factor that pushes the child into offending on others as a means of

coping or copying (Marshall & Marshall, 2000).

In terms of attachment, frequently, it can be difficult for children to create secure bonds with parental figures who frequently change (Ainsworth et al.,1978). Howes et al. (2000) stated, "Maltreating children show deficits in forming secure attachments with caregivers" (p. 96).

Poor attachment can affect the learning of skills that provide for emotional regulation and empathy within the child (Marshall & Marshall, 2000). Research has indicated that sex offenders in the adult population report disrupted and poor or insecure attachment, both to their parents as well as to relationships in general (Bogaerts, Vanheule, & DeClercq, 2005; Lyn & Burton, 2005; Marshall & Marshall).

Conduct Disorder Problems and Exposure to Crime in the Family of Origin

Of this study's sample, 25% had been exposed to crime in the family of origin and 61.3% had exhibited some form of conduct disorder other than sex offending. According to Seto and Lalumiére (2006), one of the central questions surrounding juvenile sex offending is that of the role of anti-social tendencies. Because other forms of juvenile delinquency have high correlations with anti-social tendencies, these authors stated that it is logical to speculate similarly for JSOs. In their review of the pertinent literature, Seto and Lalumiére found that JSOs tended to commit several non-sexual crimes before their sexual offense as well as after their treatment.

In a study done in the Netherlands (Wijk et al., 2007), 100 out of a sample of 240 adolescent sex offenders (42%) had committed a crime and often multiple crimes

prior to their first documented sexual offense. These crimes ranged from vandalism to assault. Though other countries have differing laws as to the age of legal accountability and define sexual offenses slightly differently than does the United States, these findings shed light on research in this country. Though the current study does not look at juvenile non-sexual crime specifically, conduct disorder is related by definition (APA, 2000). Certainly, crime is related to sexual offending because sexual offending is a crime by definition. Smith et al. (2005) stated that variables associated with increased risk of sexual offending include criminal behavior by members of the youth's family.

Personal and Family Substance Abuse

Thirty-three of the total sample (26.6%) demonstrated personal substance abuse, defined as the client's having experienced a pattern of alcohol or drug use that interfered with educational, occupational, or social functioning that was reported by parents, educators, social workers, or the client. Looking at their family contexts, sixty-three of the total sample (50.8%) demonstrated family substance abuse, defined as one or more members in the family structure using alcohol or drugs in a manner that interferes with the individual's functioning. It is understandable, then, how these adolescents potentially gained access to substances. Furthermore, with almost twice the number of parents of the sample's youth, as opposed to the youths themselves using illicit substances, it is reasonable to postulate that some of these children followed the example their parents provided for them, or, at the very least, did not resist other opportunities to abuse these substances because they did what they saw modeled (Bandura, 1963).

It has long been recognized that addictive substances can reduce inhibitions, with

alcohol cited as the most common inhibition reducer (Marshall & Marshall, 2000). One wonders at the interplay of reduced inhibitions on the part of the parents: do they then engage in sexual activities in front of their children (e.g., watching pornographic videos, having intercourse, or committing sexual offenses on their children)? Does reduced inhibition then lend itself toward greater physical abuse? What about adolescent substance abuse: do reduced inhibitions in youth lower barriers to their sexual offending?

School Performance Difficulties and School Behavior Problems

Seventy-two of the total sample (58.1%) demonstrated school performance difficulties and 63 of the total sample (50.8%) demonstrated school behavior problems. Zhang and Zhang (2005) reported a clear connection between school performance and recidivism of crime in their study on delinquency in Los Angeles. Although they recognized their recommendations as not cost-effective, still, they suggested stringent programs of tutoring and mentoring for youth with school problems to help in the prevention and amelioration of delinquency. Although it is not clear whether a reduction in delinquency was seen because of improved self-esteem and life skills, or the youth had more supervision and therefore less opportunity to re-offend, recidivism was reduced as school performance increased in the Zhang and Zhang study. Although in general, the literature tends not to discuss juvenile sex offending as a subset of delinquency, logically, it can be considered to be a form of delinquency with the legal system's taking corrective action as if this were the case. Therefore, it is logical to surmise that progress in areas of school performance and behavior might help to prevent juvenile sex offending. Similarly,

we could say that individuals with chronic poor performance in school and with chronic behavior difficulties at school appear to be at greater risk for sex offending as juveniles.

In addition to approaching school behavior problems and school performance difficulties from the JSO's vantage point, it is worth noting that sometimes lower functioning youth have lower functioning parents (Lewontin, 1975) who may not be functionally able to give their child the resources/help that he/she needs. Support for lower functioning parents could be a step in a preventative direction.

Mental Health Difficulties

Ninety-two of the total sample (74.2%) demonstrated mental health difficulties as indicated by symptoms or diagnosis of depression, anxiety, or other mental health difficulties present prior to admission for treatment at the Youthtrack RTC. This percentage is consistent with the literature's description of other samples of JSOs (Barbaree, Hudson et al., 1993; Hunter, 2000). It is unknown whether these mental health difficulties existed prior to offending and it was not assessed as to what percentage of those with mental health difficulties were being treated, either with therapy or medication. Clarity about this issue would be an avenue for future study.

It is difficult to draw conclusions from this finding, because it is impossible to determine whether these mental health issues are contributors to the overall etiology of sexual offending, a result stemming from other contributors, or are systemic and recursively related.

Social Skills Deficits

Sixty-four of the total sample (51.6%) demonstrated social skills deficits. This percentage is supported by other studies such as that conducted by Wijk, Horn, Bullens, Bijleveld, and Doreleijers (2005), who found in their Dutch study of 112 male JSOs compared with 165 non-JSO delinquents that 105 (94%) JSOs experienced problems with their peers as compared with 48 non-JSOs. Miner and Munn (2005) also corroborated this finding with their study of 78 JSOs compared with 820 non-delinquent youth: in terms of perceived isolation with respect to family, school, and peers, JSOs consistently reported feeling more isolated than non-JSOs. In a unique article written by a JSO himself (Oliver, 2007), the author reported that warning signs of his sexual offending could be seen in his complete isolation from peers due to lack of social skills and immaturity. Because younger children were less threatening, he found himself spending increasing amounts of time with them, providing him with opportunities to offend on them sexually. Cunningham (2007), in her study on bullying, found similar social skills deficits among both bullies and victims. She indicated that social skills education may increase connectedness to the school and peers and thereby reduce the incidence of bullying. For over half of the participants in the current study who struggled with poor social skills, similar interventions might have contributed to a reduction in the incidence of sexual offending.

Research Question Two: Were There Any Differences Among Variables With Respect to Facilities?

When one looks at the expected and actual numbers of clients who exhibited the variables of interest in reference to the differing RTCs in this study, those that showed statistically significant differences (frequent family structure changes, social skills deficits, mental health difficulties, and school behavior problems) are worth looking at both individually and through a systemic lens.

Logically, one might expect to see more cases of frequent family structure changes in the older group (the Brigham City clients) based purely on their ages; they had lived longer and therefore had potentially experienced more change by virtue of time alone. However, this not being the case, questions arise as to why the Logan clients experienced more family structure changes.

The author questions whether the timing of family structure disruption affects vulnerability to sexual offending. In other words, do children experiencing divorce or other loss of a parent at earlier ages lose resources that help mitigate the propensity to sexually offend? Similarly, one wonders if youth in more stable situations are handled differently when they offend and are caught, or do they simply offend less?

Furthermore, what effects does lower functioning in a child bring to a family? Is it possible that the additional stress brought about by caring for lower functioning children may create situations where parents abdicate their parenting roles due to frustration, fatigue, or other reasons surrounding the hurdles associated with lower functioning (Montes & Halterman, 2007)? Would they, perhaps, benefit from education

about parenting lower functioning children, thereby increasing their effectiveness as parents (Montes & Halterman)?

The subsample of younger and/or lower-functioning clients exhibited a higher incidence of mental health issues. This is consistent with the literature that suggests that, in general, youth who are younger or of lower intelligence suffer more mental health difficulties (Stermac & Sheridan, 1993). It is possible that with lowered intelligence, there are fewer internal resources to draw from; therefore, mental health difficulties might be more visible rather than more prevalent. This is often the case with individuals who are younger as well; they have not yet learned how to maximize the resources they have available to them, and therefore, their mental conditions may both deteriorate and may be experienced as more distressing. In addition, one would expect those experiencing greater frequent family structure changes; isolation due to greater social skills deficits; school performance difficulties; and/or exposure to concepts and experiences that children are ill-equipped to navigate, such as crime, sexuality, and/or various forms of abuse to experience greater mental health difficulties.

Similarly, literature supports the disparity between the social skills deficits observed between the two facilities (greater deficits at the facility with the lower functioning clients; Stermac & Sheridan, 1993). Social skills are a learned behavior; it is plausible to assume that those who are younger have had less time to observe and learn these skills. In the author's tenure as a therapist at the Logan Youthtrack facility, it was immediately apparent that the younger clients and those with lower IQs displayed a marked deficit in social skills. Their skills did improve over time; however, these boys

often missed simple social cues that might inform their behavior had they “caught” them.

Research Question Three: Were There Any Differences Among Variables With Respect to Race?

In comparisons related to race, there were two variables that showed significant differences: conduct disorder and personal substance abuse. According to census data for 2000, Utah is 89.2% Caucasian (U.S. Census Data, 2002). This study’s sample was 21% non-Caucasian. Although the clients of Youthtrack-Utah are not exclusively from Utah, the majority of them are. One might be tempted to utilize these findings to indict minorities with respect to conduct disorder and substance abuse. However, one has to be careful not to assume that minorities are more prone to these behaviors by virtue of their race. It is possible that as minorities, their lives are subject to greater stress factors, such as teasing, bullying, and/or prejudice, and/or they may have fewer resources available to them, which may make them more vulnerable to things such as substance abuse (National Institute on Drug Abuse, 2008a).

Research Question Four: Were There Any Differences Among Variables With Respect to Years Admitted for Treatment?

In the comparisons between years admitted to Youthtrack-Utah (1998-2002 and 2003-2007), three variables showed significant differences: early exposure to sexuality, conduct disorder (other than sexual offending), and personal substance abuse. If these differences were greater in the later years, it might be suggested that the incidence of

these variables were rising due to degradation of culture or possibly a rise in values, behaviors, and environmental factors that contribute to JSOs. However, with the results exactly opposite this (greater numbers in the earlier years), it is hypothesized that these discrepancies are due to changes that have occurred in the process of obtaining the initial assessments over the course of this study period or that more seriously offending youth were placed elsewhere.

Research Question Five: Were There Any Differences Among Variables With Respect to Client's Age at Admission?

There were no significant differences between the variables and the ages of the clients at admission. Any differences which were not statistically significant were not reported.

Research Question Six: Were There Any Statistically Significant Correlations Among the Study Variables?

When Pearson's correlations were conducted to see if any statistically significant correlations existed, many of the variables showed relationships among them. Though it may feel redundant, associations are discussed according to variable, so that the reader may look at the variables of interest directly.

Sexual Abuse

Sexual abuse showed a weak but statistically significant association with frequent family structure changes ($r^2 = .06$). This is not surprising, as literature supports the idea

that sexual abuse is more commonly perpetrated by nonbiological caretakers (Margolin & Craft, 1989). Those with frequent family changes such as divorce and remarriage have more opportunity for abuse at the hands of nonbiological parents. Barbaree and Langton (2006) listed both family structure instability and sexual exploitation as common factors within JSO families.

Early Exposure to Sexuality

Early exposure to sexuality did not show significant correlations with other variables in this study. However, Barbaree and Langton (2006) listed early exposure to sexuality as one of five common characterizations of JSO backgrounds, the others being family structure instability, sexual abuse, failure to promote and/or establish strong bonds between parent and child, and lack of resources to deal with the sexual abuse once it has been disclosed.

Non-Sexual Forms of Abuse and Neglect

Non-sexual forms of abuse and neglect showed a moderate association ($r^2 = .14$) with frequent family structure changes and a weak association ($r^2 = .05$) with school behavior problems. This latter correlation is not surprising, given what is known about the effects of abuse on children and subsequent behavior problems (CDC, 2008b). As mentioned previously, it is intuitive to assume that changes in the family structure create potential vulnerabilities to abuse due to stress or to the introduction of a new, non-biological family member.

Frequent Family Structure Changes

Frequent family changes showed statistically significant correlations with sexual abuse ($r^2 = .06$), with victims of other abuse and neglect ($r^2 = .14$), with family substance abuse ($r^2 = .05$), and with exposure to crime ($r^2 = .04$). It is interesting to note that frequent family structure changes is one of the most highly and frequently correlated variables in this study. It is logical to assume that when disruptions in family structure occur, there will be a large ripple effect into other areas of the child's life because the family is the structure for children's sense of security and safety and attachment (Ainsworth et al., 1978). One could venture to ask the question: if something could be done to prevent so many family structure changes, could the incidence of juvenile sex offending be reduced? If families were more stable, would there be less abuse and neglect? However, one could ask the question differently as well: if there was less substance abuse, would there be less crime, and therefore, more family stability (CDC, 2008a)?

Conduct Disorder Problems

Conduct disorder (other than sexual offenses), like frequent family structure changes, correlated statistically significantly with several variables: substance abuse ($r^2 = .16$), family substance abuse ($r^2 = .06$), school behavior problems ($r^2 = .12$), and exposure to crime ($r^2 = .04$). Each of these correlations seems very intuitive because they are all part of a web of interactions. Substance abuse requires a substance, whether drugs or alcohol. This requires a source, which, in turn requires money. Often, theft is associated with substance abuse, as is reduced inhibitions. School behavior problems could be

associated with violence that may be associated with the family substance abuse (U.S. Department of Health and Human Services, 2008), lack of value for education, or from the neglect that may occur as the result of parents' being disengaged due to hangovers, intoxication, or physically absent as they pursue the means to obtain more of their substance of choice. Apart from the drug/alcohol factor, as family structure changes, even under the best of circumstances, children can become upset and agitated and acting out can take the form of conduct disorder.

Exposure to Crime in the Family of Origin

Exposure to crime in the family of origin correlated with statistical significance with family substance abuse (r^2 = .09) and with conduct disorder (other than sexual offenses; r^2 = .04). These correlations are logical, given that crime is often associated with substance abuse, and conduct disorder, is, by definition, a crime. Alltucker, Bullis, Close, and Yovanoff (2006) stated that youth with a family member convicted of a felony were twice as likely to be early-start delinquents than those youth with no family felony convictions; clearly, there is a connection between crime in the family of origin and youth conduct disorder.

Personal Substance Abuse

Personal substance abuse showed statistically significant associations with several variables: conduct disorder (other than sexual offenses; r^2 = .16), family substance abuse (r^2 = .07), school behavior problems (r^2 = .07), and social skills deficits (r^2 = .05). Again, these associations intuitively make sense, although one does not know why they are

associated together. Is the youth using substances because they are socially inept? Or are they socially inept and are, therefore, using substances to "belong" to some group (National Institute on Drug Abuse, 2008b)? Are they socially deficient because their parents have not taught them these skills because of their inaccessibility due to their own substance abuse? Is the conduct disorder a result of the substance abuse (reduced inhibitions; Lightfoot & Barbaree, 1993) or is it a result of the act of getting the substances or related crimes such as thievery to make money for the substances? Although researchers can note that these factors often present together, it is not possible to separate them into cause and effect. This yields difficulty in creating effective treatment that is typically linear rather than systemic. It is precisely because of this complex web of factors that treatment of JSOs needs to address a multiplicity of interrelated factors (Hunter, 2000).

Family Substance Abuse

Family substance abuse showed the greatest number of statistically significant associations with other variables: conduct disorder (other than sexual offenses; $r^2 = .06$), exposed to crime in the family of origin ($r^2 = 9\%$), personal substance abuse ($r^2 = .07$), school performance problems ($r^2 = .06$), school behavior problems ($r^2 = .05$), and frequent family structure changes ($r^2 = .05$). As with personal substance abuse, none of these associations are surprising, yet none can be definitively labeled as the "cause" of the other. It is interesting to note that all of the correlations with this variable are relatively similar in strength. In other words, it appears there may be a nonlinear effect of family substance abuse: rather than a trickle-down effect, there is more likely a ripple

effect, where family substance abuse touches many shores within the child's life such as school performance and behavior at school; crime in the family may be replicated by the child. It is possible that there is a recursive effect between family structure and emotional health of children; distressed children's behavior is stressful on marriage and marital stress and other family structure disruptions are stressful for children. This is consistent with systems theory, which speaks to the interrelatedness and non-linearity of cause and effect within the various systems of relationships and human behaviors (Becvar & Becvar, 1999, 2003).

School Performance Difficulties

School performance difficulties showed a weak association with family substance abuse (r^2 = .06) and with school behavior problems (r^2 = .03). It is highly plausible to assume that parents struggling with substance abuse are not apt to be emotionally nor physically available to help their children with their homework. It is possible that these substances were being used while the child was in utero, which may have created fetal alcohol syndrome (CDC, 2008a) or other neurological problems that might adversely affect school performance. It has been shown that the chaos that often is associated with substance abuse adversely affects learning (O'Neill & Beaulieu, 2007). It is not uncommon for children who struggle with school performance also struggle with behavioral issues. This could be for a variety of reasons, such as ADHD, which would affect both learning and behavior simultaneously; poor self-esteem that might arise out of the poor performance that then affects behavior and/or disruptive behavior that prevents learning and therefore affects performance.

School Behavior Problems

School behavior problems were associated with conduct disorder (other than sexual offenses; $r^2 = .12$), personal substance abuse ($r^2 = .07$), school performance difficulties ($r^2 = .03$), victims of non-sexual abuse and neglect ($r^2 = .05$), and frequent family structure changes ($r^2 = .05$). There is perhaps some overlap with school behavior problems and conduct disorder in that these could be, but not necessarily, the same incident. A juvenile who vandalizes a school bathroom with graffiti might be noted by the school as having school behavior problems and might be listed by a caseworker as having conduct disorder issues. Then again, these could be totally separate; the child is a bully on the playground and shoplifts after school. As mentioned previously, these variables often work in concert with one another. Changes in family structure can open a family to abuse. Abuse often negatively affects school performance, as does substance abuse. Abuse of substances are often used to mitigate pain from abuse, divorce, or death of a parent or sibling.

Mental Health Difficulties

Mental health difficulties showed an association with social skills deficits ($r^2 = .10$). These variables also are likely recursive with each affecting the other. Children very much do not like being around other children who are different and will shun those who are awkward or “weird” (Buysse, 1997). In the face of such isolation, these children are now denied the social interaction that might give them practice that would allow them to become less odd over time.

Social Skills Deficits

Social skills deficits statistically significantly correlated with mental health difficulties (r^2 = .10) and with personal substance abuse (r^2 = .05). It is apparent that these variables interact with each other in some way. Although the common variances among the variables are not large, together, they could account for much in the overall picture of JSOs. It seems intuitive to assume that if, in the course of treatment for sex offending, one also included skills development as many JSO treatments do (K. Barlow, personal communication, May 30, 2006; Hunter, 2000), then all the factors associated with social skills deficits might also improve. This might then reduce recidivism. Mental problems, social isolation, and socials skills development are clearly linked with each other; it seems prudent to treat them in concert.

Limitations

Limitations to this study include the fact that the sample was limited to Utah RTCs and only two RTCs from the same company; referrals to this company may have some bias. Further, the sample was not racially diverse and therefore, it is difficult to draw conclusions from the data with reference to race except to say that there was an overrepresentation in comparison to the Utah population. In addition, the sample is not geographically diverse. Because of the homogenous nature of race in Utah in general, even if the sample had been more diverse, those in the minority category may have reflected inequalities in many areas that are difficult to quantify, such as perception of self or identity.

In addition, the NOJOS (Gourley et al., 2007) standards defined those placed in level six treatment as evidencing many of the variables focused upon in this study, and therefore, presence of them is expected by definition. The current study may have been more revealing if the sample had spanned all of the youth treatment levels to see which of these variables were similar and different for the different levels of offense and treatment, including all levels of juvenile sex offending.

The data gathered from the initial assessments at Youthtrack-Utah are assumed to be reliable, based on the fact that in order for a variable to be checked as “yes,” there had to be collateral reports to corroborate the information. Still, we cannot assume that the information is complete, because these youth rarely are initially forthcoming about many of the variables; this information is often revealed over time. Data for this study were gathered from initial assessments only; complete client files would likely have yielded more complete pictures of each youth’s experiences relative to the study variables.

Further limitations stem from the variables being broad in definition and therefore defined by therapists and collateral reporters in different ways, thus complicating interpretation of results of analysis and affecting their reliability and validity for this study. Greater specificity may have yielded different or more revealing results. For example, the term “sexual abuse” is fairly broad. How many of the sample had been fondled versus raped? A large percentage of those who had been sexually abused may have experienced violence in conjunction with that abuse. Thus, parents of children who have experienced violence and sexual abuse could be counseled to provide more treatment and supervision to prevent these children from offending on others.

Implications

Research

Though juvenile sex offending became a topic in its own right in the 1980s when enough research had been done to merit separating it from its adult counterpart (Fanniff & Becker, 2005; Smith et al., 2005), wide gaps still remain in the literature and therefore, more research is needed. Much of the current focus seems to revolve around treatment and recidivism rather than prevention or assessment. A great deal of the current literature on JSOs originated in the Netherlands (Bijleveld & Hendriks, 2003; Hendriks & Bijleveld, 2004, 2006; Wijk, et al., 2005, 2007) where definitions of sexual offending are somewhat different from those in the United States. Furthermore, many of the published articles are literature summaries rather than studies based on empirical data, which makes it difficult to compare the current study's data with statistics from other studies. Thus, more research needs to be conducted on U.S. samples before treatment suggestions are made.

This author believes that future studies from extant data should be drawn from the entire client file to address the issue of client dishonesty and/or naiveté in the initial assessments. Furthermore, utilizing the entire client file for gathering data would allow the researcher to be more specific about definitions or variables that are used. For example, relative to pornography use, data from the entire client file would allow a researcher to delineate between pornography on internet, in movies or magazines, and so forth. There may be differences between exposure to a Playboy centerfold versus a XXX movie. Similarly, with sexual abuse victimization, there is a difference in effect between

being talked to in a leering and degrading manner and being brutally and repeatedly anally raped. Breaking variables into more fine-tuned experiences might yield information about what kinds and levels of exposure are most detrimental to youth sexual experiences. In addition, it would be of interest to find out how many of the JSOs receiving treatment for sexual offending had previously received treatment, both in reference to sexual acting out as well as for other kinds of mental health issues, prior to their current treatment.

As a researcher, one has to entertain the many questions these data raise: How do these variables work in concert? What are the interactive effects that magnify the negative effects of any or all of these? What are the processes by which these are related to one another? For example, how does being sexually abused and/or physically abused affect school performance? How does such abuse affect mental health? Does substance abuse by family members increase the likelihood of abuse in any form? Are any of these specific enough antecedents to sexual offending that prevention is possible? Each of these questions is an area of potential future research.

Other topics worth pursuing include investigations into the resources those children possess or utilize who have been sexually abused but do not offend sexually and other variables present for those children who do respond by offending sexually. Future research might benefit from assessments that ask questions about the manner in which JSOs experienced sexual abuse. Comparisons between JSOs' experiences and their methods of perpetration might yield interesting data. Do JSOs mimic what they have experienced (Abel et al., 1993; Barbaree & Langton, 2006; Burton, 2003)? In other

words, is their sexual offending directly related to their own sexual abuse and other sexual experiences? Or, does their method of acting out sexually come from other sources such as pornography? How does the age of children, their unique abilities to process experiences including sexual abuse and exposure to sexual material, and the ability of parents to assist children in these circumstances affect future juvenile sexual offending? The author assumes that this could be useful in terms of treatment as well as prevention.

In addition, future studies could draw from assessments that take place prior to admission to treatment facilities, to determine whether the presence of depression and other mental health difficulties existed before removal from the family of origin.

Future studies could benefit from a standardized method of gathering data for initial assessments, which would allow researchers to compare years of data collection across various facilities and treatment programs to examine changes in data from year to year or era to era. This would help determine trends in juvenile sexual offending as well as factors related to offending.

There is a dearth of literature comparing both personal and family substance abuse and juvenile sex offending. Research in this area could be useful because it might give insight into prevention of juvenile sex offending; if substance abuse is somehow a contributor to juvenile sex offending, perhaps those apprehended for drug use could be flagged to receive some form of therapy or treatment that might serve to prevent offending behavior.

Corollary studies could evaluate social skills education programs to see if social skills education is effective, both in terms of prevention for at-risk youth and in terms of

treatment toward reduced recidivism of sexual offending and other crimes.

Recommendations for RTCs such as Youthtrack-Utah might include asking therapists to note specifics whenever possible in the initial assessments, such as, "client reported abuse of alcohol as well as marijuana" rather than "client reported substance abuse." This would allow those utilizing client files as data sources to describe their variables with greater specificity. Standardizing a method of data collection and strictly defining data factors would increase the reliability and validity of future data. Possible variables to add might include but not be limited to prior treatment of client, siblings or relatives arrested for sex offending, specific social skills that are deficient or absent, level of attachments to people, and indications of truthfulness.

Treatment

This study corroborates previous study findings that indicate that treatment that takes into account a host of factors beyond sexual ones is appropriate (Hunter, 2000; Långström & Lindblad, 2000; Richardson, 2005; Saleh & Vincent, 2005). Because of the interrelatedness of these factors and their systemic nature, it would be foolish to try to address one in the absence of the others (Hunter). Similarly, if there is no change in the context the individual came from, gains in therapy will likely dissipate upon return to that context. Individual therapy, family therapy, social skills education, and school performance skills are all important in treatment protocols for JSOs (K. Barlow, personal communications, May 30, 2006; Hunter).

Knowing about the interrelatedness of the study variables, it behooves therapists of JSOs to keep in mind that understanding and treatment of sexual offending should be

systemic (Hunter, 2000). When working with a boy who expresses a desire to expose himself to his therapist, the clinician has to remember that this is not solely a sexualized issue. Important factors include how the youth's desire might spring from a mental health issue; how the desire might originate in poor self-esteem and a lack of social skills with the therapist; as a way to gain the attention of an important adult; as a response to loneliness; or perhaps springing in part from the youth's own sexual abuse or poor response to that abuse on the part of caring adults. Sensitivity to the factors identified in this study as correlates to sexual offending may yield information that will affect the direction of the therapy used to address the issue of self-exposure or the manner in which an intervention is presented or implemented.

Policy

Although the author is currently unaware of policy in place that addresses the prevention of juvenile sex offending, it is a topic worth broaching, as prevention would save huge amounts of both private and federal money (Abel et al., 1993; Witt et al., 2002) as well as emotional distress for both the victims and the JSOs and their families (Barbaree, Hudson et al., 1993). There are numerous constraints to prevention, such as funding, legislation, implementation, and quality control; yet, these ideas are worth exploring. In an ideal and perfect world, there would be no juvenile sex offending; however, in the face of its existence, the best-case scenario would identify youth at risk for sexual offending based on data from this study and others to implement preventive strategies.

Similarly, once youth have offended sexually, policies regarding treatment strategies could more clearly take into account concomitant variables identified in this study and include them in systemic treatment. Although many treatment centers include families in treatment of offending youth and family treatment is increasing, such treatment varies in definition and requirements; some centers see family involvement as not helpful, and others as critical toward effective treatment (Rose, Duby, Olenick, & Weston, 1996). State guidelines for treatment could more clearly include systemic interventions. Such requirements might include funding to assist family involvement in youth treatment (Whittaker, 2000).

Conclusion

Although much more is known about the topic of juvenile sex offending than was understood in the early 1980s, there is much more to learn, especially with respect to the interrelated nature of the various factors that interact with and result from the contexts of juvenile sex offending. As the body of knowledge surrounding this phenomenon grows, it is hoped that greater strides toward prevention and efficacious treatment will also grow.

While at first glance it might seem that this study involves primarily numbers and statistics, to end with these would be to miss the individuals behind the numbers. It should be noted that part of the author’s interest in this study is drawn from her personal experiences as a therapy intern for one year at the Youthtrack-Utah, Logan RTC. During that year, the juvenile sex offender statistics became names and faces: people with personalities and feelings. There, the author grew to care for and see the perpetrators as

victims also: circumstances, contexts, abuse, neglect, and often a lack of helpful parental input. This does not remove their personal responsibility for the crimes they committed; it is still up to individuals to grow and change. However, insight into the numerous factors that played into their aberrant behaviors contributed to greater empathy on the part of the author and a belief that contexts that help ameliorate many of the factors identified in this study could help both prevent and treat youth who sexually offend. It is important for every person who studies or treats juvenile sex offenders to remember each youth in a sample represents a unique human being, each with his or her own set of complex factors.

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APPENDICES

Appendix A. Standards for Completing Initial Assessment According to JCAHO Standards

STANDARDS FOR COMPLETING ASSESSMENTS ACCORDING TO *JCAHO* STANDARDS:

DEMOGRAPHIC INFORMATION:

- What is the client's age, date of birth, gender, and ethnicity?
- Who are the client's parents or guardian and their residence?
- Did you obtain the name of the referring agency and the caseworker's name and address?

SOURCES USED TO COMPLETE ASSESSMENT

What sources did you use to gather information for the assessment. I. E. Parents.
Referral packet, previous testing completed etc.

LIVING ARRANGEMENT:

- Did you explain the client's living arrangement at Youthtrack, including briefly describing the structure, sleeping arrangements, and which subgroups the client has been assigned?
- Did you briefly explain where the client has been residing prior to attending Youthtrack?

CHIEF COMPLAINT (IN CLIENT'S WORDS):

- What is the client's understanding about why he has been placed at Youthtrack?

REASON FOR REFERRAL:

- Why was the client referred to this specific program (particular needs, level of care)?

PRESENTING PROBLEMS-INFORMATION FROM REFERRAL SOURCE:

- What specific treatment needs were identified by the referral source?
- How will the specific needs be addressed at Youthtrack?

SOCIAL HISTORY— PSYCHO-SOCIAL FUNCTIONING:

- Has the client been exposed to physical abuse, sexual abuse, neglect, poverty, trauma, or disasters?
- What do the caregivers report in regard to early socialization and attachment?
- What does the client report in regard to his friendships and social status?
- Was the client a bully, loner, was he picked on, etc.?
- What does the referral and caregivers report in regard to the client's social maturity and functioning?
- Has any specific testing been completed which could speak to personality features?

- What is the client's history of emotional and behavioral functioning?
- What is the history of maladaptive or problematic behaviors?

LARGER SYSTEM (FAMILY, PEERS, COMMUNITY SUPPORT):

- Did the client describe each member of the immediate and extended family and the significant events and interactions within the family system?
- What is the client's quality of relationship with each member?
- How does he perceive the marital or parental relationship in the family?
- What significant events did he report about the home environment?
- What does the client report about the family's financial status (ask parents as well)?
- What is the client's description of the family's ethnic and cultural status?
- How is the family perceived within their community?
- What affect has the client's treatment needs had on the family?
- What role will the family play in treatment at Youthtrack?
- What resources have the family utilized within the community?
- Does the client and/or his family report being involved in an organized religion?
- What role does religion and/or spirituality play in the life of the client?
- Who does the client report his peer group or friends to be?
- What leisure and recreational activities does the client report being involved in?
- Does the client report being involved in any organized sports, clubs, or activities?

LEGAL/CRIMINAL HISTORY & CURRENT CHARGES:

- What did the referral packet report in regard to the client's legal history?
- What did the client report in regard to his legal history?
- Did the client admit to other criminal behaviors which were previously unknown?
- Has the client ever spent time in jail or detention, been fined, been given community service hours, or been given other consequences?
- Is the client truant in paying any fines or completing hours?
- How will restitution be completed in treatment?
- What person or agency currently has legal guardianship?

PREVIOUS MEDICAL & PSYCHIATRIC HISTORY:

- What was the nature of the client's birth and early health status (ask parent as well)?
- Did the client experience normal childhood diseases (ask parent as well)?
- Has the client had up-to-date immunizations (ask parents as well)?
- What significant injuries and illnesses has the client experienced (ask parents as well)?
- What is the client's current physical status?
- Is he currently experiencing pain?
- Was there any significant findings from the initial nurse or doctor visit?
- What is the client's nutritional history and status?

- How will current problems noted be addressed in the future (medical, dental, optical, physical therapy, etc.)?
- Has the client participated in psychological or psychiatric testing? What were the results?
- What is the client's mental health treatment history? What were the outcomes?
- What is the client's psychotropic medication history?
- What current mental health symptoms are being displayed?

FAMILY PSYCHIATRIC & SUBSTANCE ABUSE HISTORY:

- What is known about the immediate and extended family's physical and psychological health (ask parents as well)?
- Have family members been hospitalized, been in mental health treatment, or used psychotropic medications (ask parents as well)?
- What is known about the immediate and extended family member's substance use history, including legal or treatment complications (ask parents as well)?

DRUG AND ALCOHOL USE: PAST / CURRENT USE:

- Has the client used alcohol, tobacco, illicit drugs, chemicals, or the use of over-the-counter medications for inappropriate purposes?
- What were patterns of use, including age of onset, frequency of use, duration, patterns, and consequences for use?
- Has the client ever passed out or had significant experiences with substances?
- Has the client ever experienced any symptoms of dependency or withdrawal symptoms?
- Has the client ever been in treatment for substance use?
- What is the client's intentions and values in regard to future substance use?

LEVEL OF SELF CARE:

- What does the client report in regard to his ability to keep himself clean and groomed?
- What does the client report in regard to his ability to complete household chores, including cleaning, laundry, cooking, vacuuming, etc.
- Do observations, information from the referral source, and reports from the family confirm or contradict these reports?
- Does the client have an employment history?
- What skills does this client report which will be conducive to independent living?
- What deficits need to be addressed in treatment? How will they be addressed?

EDUCATIONAL HISTORY AND ASSESSMENT:

- What is known about the client's educational history and performance?
- What does the client report in regard to schooling, his strength, and his weaknesses?
- What does the Woodcock-Johnson Assessment indicate in regard to
- educational standing?

- What specific educational deficiencies have been identified and how will they be addressed at Youthtrack?

MENTAL STATUS EXAM:

GENERAL APPEARANCE & BEHAVIOR OF RESIDENT:

- What is the physical appearance of the client (height, weight, features)?
- What clothing was the client wearing (at intake and in the session)? What condition were they in?
- How relaxed or nervous does the client appear?
- Does he sit still or is he more active?
- To what extent does the client focus on the assessor?

CONTENT AND ORGANIZATION OF THOUGHT:

- Did the client appear to understand the questions posed?
- Was the client able to answer the questions fully and in an understandable manner?
- Did the client take responsibility or was he evasive, blaming, or denying.
- Did the client display paranoia or other concerning thoughts?
- Was the client able to respond in an efficient manner or did there appear to be a cognitive deficit?

MOOD AND AFFECT:

- How did the client describe his mood to be during the assessment?
- Were observations consistent with his report?
- It what way did the client's affect vary during the assessment?
- Were variations in affect consistent with the topics being discussed?
- Did the client appear to be able to display a variety of emotions or did he seem restricted in any way?

INTELLECT AND ORIENTATION:

- Was the client oriented to person, time, and place? As evidenced by?
- Has any intelligence testing taken place? If so, what were the results? If not, what level of cognitive functioning would you estimate?
- Does the client's memory appear to be intact?

ASSAULTIVE & SUICIDAL IDEATION:

- Does the client have a history of assaulting others when at home, in the community, or in previous treatment programs?
- Does the client any desire to harm any individuals at this time?
- Does the client have a history of suicidal attempts or ideation?
- Does the client report any current suicidal ideation?
- Does the client report ever making plans to commit suicide?

SEXUAL BEHAVIOR:

- What are the client's first memories of sexual experiences?
- Does the client report being sexually abused?
- What sexual behaviors were observed in the home and community?

- What family boundaries surrounding sexuality and modesty are described?
- How was sexuality discussed in the home?
- What rules regarding media and sexual influences were in the home?
- Where did the client gain access to pornography, if relevant?
- What consensual sexual experiences does the client report?
- What episodes of sexual abuse by the client did he report, or were reported?
- Does the client or referral agency report that the client sexually acted out while in a treatment or correctional placement?
- Does the client report any behaviors which may indicate a fetish or paraphilia?
- What types of sexual fantasies and urges does the client report experiencing recently?
- What does the client report regarding his sexual orientation and/or sexual preferences?

DSM-IV DIAGNOSIS

- Did you speak to the sexual offender issues as well as depressive, anxiety, psychotic, impulse-control, substance use, elimination control, sleeping, and other symptoms, on Axis I?
- Did you examine intellectual functioning for Axis II?
- Did you list all medical conditions known on Axis III?
- Did you list all relevant stressors on Axis IV?
- Did you complete the GAF, from page 32 of the DSM-IV?

PSYCHIATRIC RECOMMENDATIONS:

- What medications was the client taking at admission?
- Do they appear to be adequate for the mental health needs?
- What other mental health symptoms or concerns should the psychiatrist investigate?

PSYCHOMETRIC DATA:

- *Sexual Adjustment Inventory – Juvenile* (look specifically at the results of the substance use sections to determine whether additional assessment in required).
- *Beck Depression Inventory*
- *Sexual Projective Card Set*
- *Minnesota Multiphasic Personality Inventory – Adolescent*
- *Pre-Treatment Behavior Indicator*

RISK FACTORS (SAFETY PLAN):

- What level of risk does the client present for suicidal ideation or self-harm?
- What level of risk does the client present for assaultive behaviors?
- What level of risk does the client present for sexually acting out or offending on someone?
- What level of risk does the client present for eloping from the program?
- What other risk factors does the client present?

DISCHARGE PLAN:

- What does the client report being his preferred discharge placement?
- What does the family report being their preferred discharge placement?
- What does the referring agency report being their discharge placement?
- What needs to be accomplished to attain the desired placement?
- What secondary options are there?

SUMMARY OF FINDINGS AND PRESCRIPTION:

- Did you summarize the specific reasons that treatment is required?
- Did you list individual therapy as a prescription?
- Did you list family therapy as a prescription?
- Did you list group therapy as a prescription?
- Did you list medication management as a prescription?
- Did you list social skills development as a prescription?
- Did you list education as a prescription?

Appendix B. Permission Letter to Use Data

QuickTime™ and a
TIFF (LZW) decompressor
are needed to see this picture.

Appendix C. Data Collection Chart

Youthtrack-Utah Client Data Collection

Client ID	Program	Gender	Ethnicity	VSA	EES	VAN	FFS	OCD	EXC	PSA	FSA	SPD	SBP	MHD	SSD			

VSA = Victim of Sexual Abuse (as per client report and one other collateral report)
EES = Exposure to Early Sexuality (chronic pornography in the home; unregulated media influences; open sexuality amongst adults;etc)
VAN = Victim of other forms of Abuse or Neglect or traumas (as per client report and one other collateral report)
FFS = Frequent Family Structure changes (marriages, divorces, entering and ending cohabiting relationships [at least 1 every 2 years])
OCD = Other types of Conduct Disorder problems (as per diagnosis, client report, or collateral reports)
EXC = Exposure to Crime in the family of origin (at least two episodes of crimes against people or property)
PSA = Personal Substance Abuse (pattern of alcohol or drug use that intereferes with educational, occupational, or social functioning)
FSA = Exposure to Family Substance Abuse (one or more members use that interferes with primary individual's functioning)
SPD = School Performance Difficuities (chronic history of poor or failing grades)
SBP = School Behavior Problems (frequent trouble with teachers, resulting in discipline, including detention, suspension, expelled, etc).
MHD = Mental Health Difficuties (symptoms or diagnosis of depression, anxiety, or other mental health difficulties)
SSD = Social Skills Deficits (history of few same age friends, social isoltion, etc.)